

Policy Report

CIVIL COMMITMENT *under* MEDICAID MANAGED CARE



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services



Policy Report



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Executive Summary

This report presents findings from an exploratory study of the relationship between Medicaid managed behavioral health care and the use of inpatient civil commitment. Data collection methods included a literature review of Medicaid managed behavioral health care, civil commitment, and the relationship between the two; in-depth telephone interviews with policy experts; and interviews with stakeholder representatives in nine States to ascertain how civil commitment is handled in each State's Medicaid managed care contract, and any specific results that were observed. The interview questions focused on the following issues:

Has the State addressed the issue of civil commitment in its Medicaid managed care contract? If so, does the contract clearly specify:

- Whether and under what circumstances the managed care organization (MCO) is responsible to pay for court-ordered service?
- Where court-ordered hospitalization will take place and whether the MCO is responsible to pay for care in an institution for mental disease (IMD)?¹
- What services will be deemed medically necessary and how this determination will occur?

- Whether the capitation rate includes the cost of court-ordered services? Is there is some form of incentive in the contract that would encourage the use of civil commitment?

Other study questions were:

- How do stakeholders believe such contract provisions (or lack thereof) have affected the use of civil commitment within each State?
- Will any anticipated changes to future managed care contracts limit use of civil commitment?

Although some information was gathered about relevant contract provisions for each of the nine study sites, only four States—Colorado, Iowa, Wisconsin, and Minnesota—were able to offer a comprehensive view of the issue. Case studies for these four States were thus developed and included in this report.

Clearly, States vary considerably in terms of their Medicaid managed care financing arrangements, their civil commitment statutes and patterns of use, and the manner in which

¹ An institution for mental disease is defined as any facility with 16 or more beds devoted exclusively to the delivery of psychiatric services. Under the Federal Medicaid statutes, Medicaid funds cannot be used to pay for IMD services for adults between the ages of 21 and 64. The intent of this provision, enacted in 1965, was to ensure that the States' traditional responsibility for funding State mental hospitals is not shifted to the Medicaid program. However, States may opt to cover IMD treatment for individuals under 21 years of age or over 64 years of age.

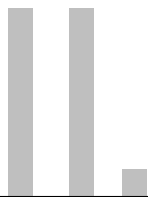
civil commitment issues are addressed in Medicaid managed care contracts. Nevertheless, the case study interviews did suggest some relatively consistent observations on the probable relationship between Medicaid managed care contract provisions and the use of civil commitment:

- **Increased use of court-ordered treatment may occur if an MCO contract does not address the issue of who is fiscally responsible for costs associated with civil commitment.** The absence of clear contract provisions may create incentives for the MCO to use civil commitment as a way to shift costs to the State mental health authority or to counties. Some MCOs rely on principles of private insurance law to deny the medical necessity of court-ordered services automatically. Others rely on the Medicaid IMD exclusion to deny payment for court-ordered services provided in State hospitals. Contracts that anticipate and address potential cost-shifting may prevent an increase in the frequency of civil commitment.
- **Collaboration between the judiciary and the MCO may reduce the incidence of court orders to inpatient settings.** Many judges, with limited knowledge of treatment options within the community, may routinely order civilly committed individuals to inpatient settings, including settings (such as State hospitals) outside the MCO's provider network. Communication between the courts and the MCO often results in treatment in less restrictive settings and also allows the MCO to better manage treatment costs.
- **Systems that overly restrict access to services may increase the use of civil commitment as a way to obtain treatment.** One such restrictive policy is the use of a nar-

row "medical model" definition of medical necessity. Such a definition may leave the MCO too much latitude to deny payment for services required by persons with serious mental illness. Medicaid managed care contracts can address policies related to treatment accessibility so that needed services can be obtained without resorting to court orders.

- **A comprehensive system of community-based treatment and supports may reduce the need for civil commitment.** The types of supportive services required to enhance the probability of an individual's stable functioning in community settings are well established, but are not always included in Medicaid managed behavioral health care programs. (In the absence of such services, the condition of a person with mental illness may be more likely to worsen and lead to civil commitment.) Contracts that require the MCO to develop strong community supports may result in a system more responsive to the consumers' needs, thereby reducing the need for civil commitment.

The dearth of quantitative data from the study sites limited the ability to draw more comprehensive conclusions about the relationship between Medicaid managed care and civil commitment. Specifically, most States do not keep records of the number of civil commitment orders made for persons with mental illness. Thus, one of the key policy suggestions to emerge from this study is that States should track this information—for inpatient as well as outpatient settings—particularly if they are implementing a Medicaid managed behavioral health care system. Only with valid and reliable longitudinal data will future research be able to identify clear trends in the use of civil commitment procedures.



Introduction and Overview

Among the most controversial practices engaged in by mental health practitioners are involuntary interventions. Civil commitment—the process by which an individual is compelled to receive treatment for a mental illness—has long been a point of contention among clinicians, family members, people with mental illnesses, and advocates. The debate now also extends to commitment to treatment in outpatient settings, a practice that has grown in frequency in recent years. At the heart of the issue is the need to strike a balance among frequently conflicting concerns:

- Protecting the interests of those whose illnesses may impair their judgment or ability to care for themselves.
- Maintaining the rights and dignity of the individual.
- Ensuring the safety and welfare of the community and the individual.
- Encouraging acceptance of those whose behaviors may not conform to social norms.

Although some advocates oppose any form of coerced treatment, other stakeholders, including many consumers, accept the *limited* use of court commitment as an unfortunate, but necessary, part of mental health care. There is widespread agreement that civil commitment should be a measure of last resort and that efforts should be undertaken to make the process more humane than is often the case (Blanch, 1992; Mancuso, 1997).

The advent of Medicaid managed behavioral health care has given rise to new issues around the process of civil commitment. These include disagreements over criteria

used to assess the need for treatment, who decides what type of treatment is necessary, how and where the treatment is provided, and who—the managed care contractor or the Mental Health Authority (which may be at the State or county level)—is fiscally responsible when treatment is ordered by the courts. Concern has also been raised about the frequency with which court-ordered commitment is being used under Medicaid managed care. Some have argued that because a managed care organization (MCO) has the authority to deny payment for services, the use of court orders for treatment may *increase* because civil commitment can ensure consumers' access to needed services. Others have said that the use of civil commitment should effectively *decrease*, asserting that under cost-controlling managed care, expensive services such as inpatient hospitalization will be replaced by less costly and less restrictive treatment within the community (Bazelon Center, 1995). Finally, some advocates and policy analysts have expressed concern that court orders could act as a

mechanism to *shift the responsibility* for high-need clients—and their associated costs—from the MCO onto another payer (see, for example, Bazelon Center, 1995; Petrila, 1995).

To date, evidence supporting any of the foregoing views is largely anecdotal. Little carefully constructed, empirical research has been conducted to ascertain the frequency of court-ordered commitment under managed care arrangements or to determine whether economic incentives correlate with a change in frequency.

Statement of the Problem

This exploratory study on the relationship between Medicaid managed care and civil commitment² in a few selected States is an effort to begin addressing these questions. Specific study questions asked include the following:

- Has the State addressed the issue of civil commitment in its Medicaid managed care contract? If so, does the contract clearly specify the following four points?
 - Whether and under what circumstances the MCO is responsible to pay for court-ordered service.

² Although the American Bar Association (1995) defines eight possible types of civil commitment, in this report the term will be used to refer to only three instances of forced treatment:

- a. *Third-party commitment*, in which an individual who has no legal relationship to the consumer petitions to have the individual committed to an inpatient facility for treatment.
- b. *Short-term commitment* (usually 3–5 days) to an inpatient facility for a mental status evaluation. This type of commitment is also referred to as "emergency commitment" and usually does not require judicial proceedings.
- c. *Extended commitment* (30–90 days or longer) to an inpatient facility subsequent to the findings of the emergency evaluation. The extended commitment requires due process.

- Where court-ordered hospitalization will take place and whether the MCO is responsible to pay for care in an institution for mental disease (IMD).³
- What services will be deemed medically necessary and how this determination will occur.
- Whether the capitation rate includes the cost of court-ordered services, and whether there is some form of incentive in the contract that would encourage the use of civil commitment.

- How do stakeholders believe these contract provisions (or lack thereof) have affected the use of civil commitment within each system?
- Are there anticipated changes to future managed care contracts to limit the use of civil commitment?

It is important to recognize that differences exist in the structure of State mental health systems and that wide variations occur in the way that managed care plans are designed and implemented. Indeed, probably no two completely identical implementations of Medicaid managed behavioral health care exist in the nation. Thus, the case studies in this report are not exhaustive of the possible ways in which managed care

³ An institution for mental disease—or IMD—is defined as any facility with 16 or more beds that is devoted exclusively to the delivery of psychiatric services. Under the Federal Medicaid statutes, Medicaid funds cannot be used to pay for IMD services for adults between the ages of 21 and 64. The purpose of this provision, enacted at the start of Medicaid in 1965, was to ensure that the States' traditional responsibility for funding State mental hospitals was not shifted to the new Medicaid program. States may elect to cover individuals under 21 or over 64 years of age in IMDs, but this is not mandatory.

contracts can address civil commitment. Rather, they illustrate four States' contract provisions and experiences. In Wisconsin, for example, the MCO is required to pay for any enrollee who is court-committed to treatment; however, the contractor is *not* responsible for IMD-based care for adults. In contrast, managed care contractors in Colorado must pay for "any and all" court-ordered services—including IMD care—even if the contractor does not believe the criteria for medical necessity are met.

The managed care contract in Iowa establishes something of a balance between State and contractor responsibilities. The MCO automatically covers any 5-day inpatient mental health evaluation, but bears the cost of extended commitment only if the treatment meets the criteria for psychosocial⁴ necessity and is offered by an in-network provider. In addition, the contractor is not required to pay for IMD services unless the overall cost of IMD treatment exceeds the level that was experienced prior to the implementation of Medicaid managed care. If IMD utilization expenses exceed that baseline level, then the MCO must assume any subsequent costs for that year.

Finally, Minnesota offers an example of a Medicaid managed care contract that has approached civil commitment in piecemeal fashion. Reportedly, the original managed care contract in this State did not contain provisions related to civil commitment; there was no mention of the IMD exclusion or any provision detailing the contractor's fiscal responsibility for court-ordered treatment.

⁴ Iowa has extended the concept of medical necessity in its managed care contract, establishing criteria for treatment that will meet the psychosocial needs of the enrolled population. This is discussed in greater detail in the Iowa case study (Appendix, Case Study C).

This oversight—perceived by our interviewees as damaging to both consumers and the overall mental health system—resulted in a legislative remedy to issues that have been addressed in other States' Medicaid managed care contracts.

Civil Commitment

The American Bar Association's (ABA's) Commission on Mental and Physical Disability Law describes civil commitment as the following:

...the process by which individuals with mental illnesses or mental impairments, such as mental retardation, developmental disabilities, substance abuse, or alcoholism, are compelled to receive care and treatment for these conditions, either in inpatient or outpatient settings (ABA, 1995).

For an individual to be civilly committed to treatment, most States require evidence that the person presents an immediate danger to self or others (see Linburn, 1998), or that she or he is "gravely disabled" (a condition often viewed as an indicator of "danger to self"). Because "dangerousness" can be difficult to establish, some States have added an "in need of treatment" criterion to their civil commitment statutes (e.g., Arizona—see ABA, 1995). Although precise legislative language for these criteria may vary considerably across jurisdictions (Rubin, Snapp, Panzano, & Taynor, 1996), the general process of civil commitment is fairly consistent. In almost all cases, an initial petition is filed, based on an assessment that an individual in question represents an imminent danger to self or others or is in need of immediate treatment. On the basis of this emergency petition, the individual may be placed in a secure inpatient facility for a short-term commitment (also referred to as an "emergency

commitment” or “observational commitment”[ABA, 1995]). In many States, under such an emergency petition, the individual may be committed without a court hearing. However, most States do limit the length of time the individual may be detained (usually 72 hours).

At the end of the initial commitment period, the individual must be either released or must receive a court hearing to assess the need for an extended commitment. Such a hearing aims to determine if the individual meets the State’s legal criteria for commitment (“danger to self/others,” etc.). Extended commitments usually are also time-limited, although the duration is substantially longer than an observation period. In addition, most jurisdictions require that these orders be reviewed periodically, to ensure that an individual who no longer meets the commitment criteria is not held indefinitely (ABA, 1995).

The civil commitment process varies somewhat across the States in this study. For example, in Colorado an individual who is perceived as dangerous may be brought to a mental health facility by a police officer or licensed clinician for further evaluation. The initial commitment period is for 72 hours,⁵ after which a court hearing must be conducted to assess the individual’s need for further treatment. Both the judge and an MCO representative have input into the type of treatment that they believe will most likely benefit the individual. In Colorado, extended commitment is for 90 days, during which time the consumer may choose to challenge the commitment order.

⁵ Of the four States included as case studies in this report, Colorado, Minnesota, and Wisconsin enforce an initial 72-hour emergency commitment, while Iowa has a 5-day evaluation period.

In marked contrast, a police officer or physician can file an emergency commitment in Massachusetts to hold and treat an individual for up to 24 days. During this nearly month-long period, the individual must be evaluated and offered appropriate treatments. At the end of the 24 days, a petition may be brought before the court to seek extended commitment. Neither the extended commitment period nor the location of treatment is specified in State statute or regulation; these are left to the discretion of the court, which may seek physician input. One interviewee from Massachusetts noted that these long holding periods (compared with other States in this study) may contribute to the relative rarity of extended civil commitment in this jurisdiction.

Regardless of how States have structured their civil commitment processes, mental health consumers around the country have expressed serious concerns about what they perceive to be an abrogation of their civil rights. Families, the judiciary, and many providers view civil commitment as a way to ensure care, particularly for those unable to consent to treatment. Consumers, however, have asserted that the process merely uses the legal system to deprive individuals of their personal liberty (ABA, 1995, p. 19). The move to Medicaid managed care further highlights these concerns, and brings yet another voice—the MCO—into the medical and legal decision-making processes.

Medicaid Managed Behavioral Health Care

As many policy analysts have pointed out (e.g., Bazelon Center, 1995; Dorwart, 1990), “managed care” is not a single financing arrangement, but rather is a term applied to a range of approaches that emphasize provision of coordinated and appropriate health

services in a cost-efficient manner. Such arrangements may range from aggressive utilization review and discounted fee-for-service plans to capitated payments. Under capitation, the MCO either may receive payments and operate under a discounted fee-for-service plan or may opt to subcapitate to local providers.

The national trend toward the management of health care costs began in earnest in the 1980s, sparked by reports of a 12 to 15 percent annualized growth rate in the industry (Dorwart, 1990, p. 1088). A particular focus of the managed care movement was behavioral health services, the costs of which were reported to be rising far faster than other aspects of health care, thereby threatening to bankrupt private insurance carriers. As Cuffel, Snowden, Masland, and Piccagli (1996) note, although the validity of these reports was questionable, the concern fueled an entire industry of private-sector managed behavioral health care organizations.

Faced with similar issues of uncontrolled growth and increasing expenditures, the management of public-sector health care was not far behind that taking place in private industry (see Cuffel et al., 1996; Feldman, Baker, & Penner, 1997; Hadley, Schinnar, & Rothbard, 1992). The Medicaid program, for example, ranks as one of the fastest-growing components of both Federal and State budgets. It is currently the major source of mental health services funding in the United States; approximately 42 percent of mental health service dollars come from Medicaid (Lewin Group, 1997). Recent studies have found that in 1993, Medicaid cost \$100 billion more and served 10 million more beneficiaries than it did a decade earlier (Behavioral Health Management, 1995). The average State Medicaid expenditure as a

percentage of total State expenditures increased from 17.8 percent to 19.4 percent between 1992 and 1994 (National Association of State Budget Officers, 1995).

The initial public-sector shift to Medicaid managed care thus grew out of States' desires to get the most out of limited Medicaid dollars while maintaining essential coverage for vulnerable populations. To move Medicaid recipients to a managed care arrangement, however, States have been required to apply for and receive Federal "waivers" from particular requirements of the Medicaid statute. The Health Care Financing Administration, the Federal agency responsible for the Medicaid program, may grant either of two types of waiver to States that want to institute a managed care system. Under the Section 1915b waiver—the more limited of the two options—States may restrict the range of providers from whom beneficiaries can receive services, but are allowed little other flexibility in program design or coverage (Bazelon Center, 1995; Policy Resource Center, 1996). This type of waiver is granted for a 2-year period, after which new application must be made.

In contrast, under the Section 1115 research and demonstration waiver, States are permitted tremendous flexibility in how they administer their Medicaid program. Upon receipt of this waiver, States may expand eligibility criteria for Medicaid enrollment, enhance the range of services offered to specified populations, or allow alterations in Medicaid reimbursement requirements. The 1115 waiver is granted for a 5-year period. Only after an evaluation of its impact may a new waiver be granted to the State.

Under either waiver, behavioral health services financing can be managed in a num-

ber of ways. For example, in some State Medicaid plans (such as the BadgerCare program in Wisconsin), mental health and substance abuse services are part of a fully integrated managed care plan—one that covers mental as well as physical disorders. The advantage of this arrangement is that a single insurer covers the beneficiary, facilitating treatment of mental health as well as primary health needs. Particularly for an individual with a serious mental illness, the disadvantages of such a plan are numerous, and include the potential of missed or incorrect diagnoses and treatments (see Bazelon Center, 1995). In addition, as the Bazelon Center (1995) has noted, such plans usually are oriented toward acute illnesses and, thus, are less attuned to issues faced by individuals with chronic disorders.

The potential difficulties of an integrated plan for seriously mentally ill enrollees have led some States to separate behavioral health coverage from the physical health care plan. In some cases, such as the Iowa Plan, mental health and substance abuse services have been placed in a separate, specialized managed behavioral health care plan; such an arrangement is known as a full carve-out. In other instances, either mental health or substance abuse services are covered by a plan separate from all other health care coverage. This arrangement is known as a partial carve-out, represented in this report by the Colorado Mental Health Capitation and Managed Care Program.

The potential advantage of a carve-out arrangement is clear for enrollees with a serious mental illness or substance abuse problem. The health care plan specializes in meeting the diverse needs of the covered population. Thus, inpatient hospitalization or assertive community treatment may be

standard, covered plan benefits. The obvious disadvantage to separate behavioral and physical health care coverage is that the person with a serious mental illness may not get his or her physical health needs adequately cared for (Bazelon Center, 1995).

Finally, some States may exclude individuals with behavioral health needs from the managed care plan altogether, retaining mental health and substance abuse services under a traditional fee-for-service arrangement. Minnesota, whose current Medicaid managed care plan covers only those individuals with acute mental health care needs, is such an example. Although this arrangement may work well for States with limited resources, the Bazelon Center notes that this design “perpetuates the second-class status of people with mental illness and the second-class care they receive” (Bazelon Center, 1995).

Civil Commitment and Medicaid Managed Behavioral Health Care

As individual policy issues, civil commitment and managed behavioral health care are controversial, each subject to debate among policy analysts, health care providers, consumers, and members of other stakeholder groups. Little attention has been directed to issues at the intersection of these two policy arenas. Yet even in the limited exploration of the topic, markedly different conclusions have been reached about how best to address civil commitment in the context of Medicaid managed care contracts.

Many individuals, including several health policy experts, argue that Medicaid managed care contracts should include explicit provisions around how the MCO will address civil commitment. For example, John Petrila (1995 and personal interview) and the

Bazelon Center (1995) contend that the contract should delineate explicitly whether the MCO bears responsibility to pay for court-ordered services. If the MCO is exempt from responsibility or if the contract is silent, the MCO may perceive an incentive to use civil commitment to shift responsibility for costs and patients onto another payer (e.g., the county or State).

Similarly, some have posited that the contract should address the question of where court-ordered hospitalization will take place as well as the MCO's relative responsibility for IMD care. Under Federal Medicaid law, Medicaid funds cannot be used to pay for IMD care provided to adults ages 22 to 65 (see footnote 1). If most civilly committed consumers are hospitalized in IMDs (such as State hospitals), and if the contract does not specify the MCO's responsibility for associated costs, once again the MCO can use civil commitment and treatment in an IMD to shift responsibility for high-cost consumers onto another payer.

In addition, consumer and provider groups alike have argued that the contract should detail explicitly the services deemed "medically necessary" under Medicaid managed care, as well as how this determination is made for the individual consumer (see, for example, Bazelon Center, 1998). Otherwise, if an MCO has latitude to find certain high-cost services to be "not medically necessary," providers (or others in the system) might use the civil commitment process to give consumers access to needed, but otherwise uncovered, services (Petrila, 1998).

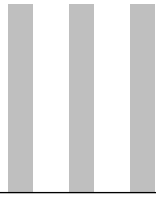
Finally, those favoring explicit contract language suggest that the contract should

require coverage for certain community-based services, as well as include provisions ensuring the availability of appropriate community supports. A number of experts consulted noted that many civil commitments are the result of a mental health service system with insufficient supports within the community. The underserved person, they argue, may deteriorate at home and may ultimately be committed, usually to an inpatient unit.

Some consumers and consumer groups posit that any form of coerced treatment is inappropriate treatment. Therefore, they oppose any specific mention of civil commitment in Medicaid managed care contracts. Thus, if a contract allocates funds to an MCO to cover the cost of court-ordered services, the MCO has an incentive to use the civil commitment process—a covered service—frequently. Similarly, these consumer advocates reject capitation rates that include the cost of court-ordered services, as well as other contract incentives that appear to encourage the use of civil commitment.

Organization of the Report

This report describes how several specific States address civil commitment in their Medicaid managed care contracts, and explores the effect of those contract provisions (or lack thereof) on the frequency or manner in which civil commitment is used in those jurisdictions. Chapter 2 presents the methodology used in conducting this study. Chapter 3 presents case studies of four States. Chapter 4 summarizes findings and offers some suggestions for further research on these issues.



Methodology

The goal of this project was to explore how civil commitment has been addressed in Medicaid managed behavioral health care contracts. The methodology included three major tasks: First, the literature on managed care, court-ordered treatment, and the intersection of these two policy arenas was reviewed. Second, in-depth interviews were conducted with policy experts to determine their views on how Medicaid managed care contracts should (or should not) address court-ordered treatment. Finally, interviews with stakeholder representatives in nine States sought to ascertain how civil commitment has been handled in each State's Medicaid managed care contract. The four States from which the most comprehensive information was obtained have been included as case studies. Study methods are described in further detail below.

Literature Review

The first task was to conduct an extensive literature review on the relationship between Medicaid managed care and civil commitment. The search included traditional methods of searching the published literature as well as efforts to identify ongoing and unpublished studies, organizations with relevant knowledge and expertise, and materials available on the Internet. Both primary sources and previously prepared literature reviews were examined.⁶ The starting point was a base of extensive literature reviews already available on the topics of managed behavioral health care and civil commitment. These existing sources were updated using a variety of search engines for customized

Internet searches. Once a draft literature review was prepared, the various experts interviewed (discussed below) were asked to identify any relevant materials the search might have missed.

The second step in the process was to assess the relevance of the literature selected to the specific topic of interest. Both Medicaid managed behavioral health care and civil commitment have received extensive attention in the published literature and other sources. However, with the exception of the few sources discussed below, almost nothing has been written about the relationship between Medicaid managed behavioral health care and civil commitment.

Managed care as a whole has been the subject of great attention. A significant literature on the topic of Medicaid managed behavioral health care has also developed, addressing a number of issues. Several authors focused on the positive and negative

⁶ These included, among others, bibliographies developed by the National Technical Assistance Center for State Mental Health Planning, the National Resource Center on Homelessness and Mental Illness, and the Mental Health Policy Resource Center (now a part of the Lewin Group).

implications of introducing a third party, often a for-profit corporation, into the not-for-profit public-sector mental health system. Some concluded that the greater flexibility of capitation funding produces an increased number of community-based services, such as expanded community supports, consumer-run services, and crisis respite services (American Managed Behavioral Healthcare Association [AMBHA], 1998; Government Accounting Office [GAO], 1999; Hadley, 1996). These services often are considered more appropriate for individuals with mental illnesses than is more costly inpatient care (e.g., Feldman, 1992; Goldman & Feldman, 1992; Hadley, 1996).

Other authors, however, have questioned the ability of the private managed care sector to meet the broad-ranging and intensive needs of this highly vulnerable population. Managed care organizations (MCOs), they suggest, are accustomed to managing risk for employers whose workers are generally healthy and need only occasional, acute interventions. How well, they ask, will these organizations be able to anticipate the service needs of Medicaid clients (e.g., Bazelon Center, 1995; Cuffel et al., 1996; Feldman et al., 1997)?

Concerns about the impact of managed care financing on public-sector service delivery have led several mental health policy researchers to explore key issues such as consumers' access to services under managed care (Hadley et al., 1992; *Psychiatric News*, 1997) and the quality and effectiveness of those services (e.g., Cole, Reed, Babigan, Brown, & Fray, 1994; Center for Health Policy Studies, 1996; England & Vaccaro, 1991; Schlesinger, Dorwart, & Epstein, 1996). Concern about accountability has contributed to the development of outcome

measures, including assessments of the mental health service system's ability to maintain consumers in the community, measures of clinical change over time, and evaluations of consumer service satisfaction.

Several organizations have published manuals delineating how the State Mental Health Authorities (SMHAs) and Medicaid agencies can develop Statewide Medicaid managed behavioral health care contracts (e.g., Bazelon Center, 1995; Hall, Edgar, & Flynn, 1998; SAMHSA, 1998). Issues discussed include the relative merits of different financing mechanisms (e.g., integrated or carve-out plans—see Chapter 1), specific provisions to be included in the contract (e.g., required coverage of certain services; mandated quality assurance mechanisms), and ways to ensure that consumers' rights are maintained in the new system (e.g., nondiscrimination policies, the establishment of grievance procedures).

The literature on Medicaid managed care includes very few references to civil commitment. Similarly, the sizable body of literature on civil commitment includes few discussions of Medicaid managed care and almost none of the effect of Medicaid managed care on the commitment process. Much of the civil commitment literature addresses the topic in relation to the rights of people with mental illnesses, particularly the right to obtain desired and clinically appropriate treatment in the least restrictive manner possible (see Bursten, 1986; Blanch, 1992; Campbell, 1997; Coursey, Farrell, & Zahniser, 1991; Garrett & Posey, 1993; Mancuso, 1997; among others).

Another frequently occurring theme in articles on civil commitment is the highly aversive character of the process. Sources of concern included the sometimes harsh role of the police, the emergency room waiting time, and the trauma of appearing at a court hear-

ing at which family members and others testify. Regardless of the author's position on the necessity for or appropriateness of civil commitment, the literature was in accord that the civil commitment process should and could be conducted in a more humane manner (American Psychiatric Association [APA], 1998; Garrett & Posey, 1993; Lefley, 1993).

Another theme in the literature on civil commitment is the need for further research on the effectiveness of involuntary treatment. Many mental health services researchers have explored the clinical effectiveness of civil commitment to inpatient as well as outpatient settings (e.g., Carroll, 1991; Hiday, 1988, 1992; Geller, 1995; Maloy, 1996; Monahan, Hoge, Lidz, & Eisenberg, 1996; Nicholson, Ekenstam, & Norwood, 1996; Swartz, Burns, Hiday, George, Swanson, & Wagner, 1995; among others). However, these studies have yet to lead to a consensus on the most appropriate direction for mental health policy. The difficulty is due in part to the difficulty of designing rigorous research on such a sensitive and controversial topic, and in part to the strongly divided feelings of the various stakeholders⁷ (Policy Research Associates, 1998; Telson, Glickstein, & Trujillo, 1999).

While these bodies of literature enhance understanding of both Medicaid managed care and civil commitment, little in the literature addresses the relationship between the two topics. Indeed, only two⁸ primary sources discuss how civil commitment is being or might be undertaken under Medicaid managed care. In 1995, for example, the Bazelon Center for Mental Health Law published *Managing Managed Care for Publicly Financed Mental Health Systems*, a primer on the policy implications of moving to pub-

lic-sector managed care financing. Among the issues discussed in the booklet are the merits of different financing structures (e.g., full or partial carve-outs, integrated approaches), the protection of consumers' rights, and the establishment of quality assurance measures. In addition, the publication offers some discussion on civil commitment, offering several steps to take to avoid adverse consequences for people with mental illness. The steps discussed include the importance of requiring the MCO to assume fiscal responsibility for civilly committed individuals (in order to avoid a cost-shifting incentive); the development of an array of alternative services within the community, such as crisis residential programs; and the requirement that consumers be active participants in treatment decisions, particularly regarding any treatment plan expressed in an advance directive.⁹

⁷ The Bellevue (New York) Outpatient Commitment study resulted in just such a controversy. While study findings revealed no statistically significant differences between the treatment (outpatient commitment) and control (no commitment order) groups (Policy Research Associates, 1998), physicians at the hospital sharply criticized both the findings and the study design that yielded these results (Telson, Glickstein, & Trujillo, 1999).

⁸ The Center for Substance Abuse Treatment (CSAT) Technical Assistance Paper 22 (1998) is an additional reference that briefly discusses the importance of addressing civil commitment issues within the Medicaid managed care contract. The points raised in this one-page discussion, however, mirror those made both by the Bazelon Center and John Petrila, two sources most informative on the study topic. Consequently, the manuscript is not discussed in any detail in this section.

⁹ Advance directives are patient- or consumer-created documents that spell out an individual's desired treatment intervention in the event of incapacity that precludes participation in an emergency decision-making process. Although advance directives are discussed briefly toward the end of this report, additional information can be found in a policy paper published by the Bazelon Center (1999).

The Bazelon Center also has examined the importance of expanding and clearly defining the meaning of “medical necessity” in Medicaid managed care contracts (see Bazelon Center, 1998). Because the “medical necessity” of a clinical intervention may be subject to wide interpretation, this issue has long been a point of contention within a managed care environment (see Ford, 1998). Bazelon suggests that the standard medical model of treatment is not appropriate for public-sector clients with mental illness; yet a definition lacking clarity might leave the MCO with excessive latitude to deny treatment. Although denying treatment may help control costs, the authors note that, in the absence of timely behavioral health intervention, an individual with mental illness may deteriorate to the point of civil commitment to an inpatient facility. The authors recommend an enhanced definition of medical necessity designed to protect plan enrollees from such adverse consequences.

Attorney and mental health policy expert John Petrila has been a second invaluable source of information. He has written two journal articles directly addressing civil commitment under Medicaid managed care. In a 1995 article, Petrila argued that if contracts fail to address an MCO’s fiscal responsibility for civilly committed enrollees—particularly in those cases where court commitments are made to IMDs, such as State hospitals—the MCO can use the civil commitment procedure as a de facto “stop-loss” for high-cost consumers. Petrila encourages adoption of specific contract provisions around payment responsibility, including provisions to preclude cost-shifting by the MCO.

These issues were reiterated 3 years later in 1998, when Petrila examined the often conflicting relationship between the judiciary

that may remand an individual to treatment and the MCO that must assume related costs. He posits that the interrelated roles of the MCO and the judiciary dictate that they engage in open dialogue to assess alternatives to hospitalization that not only would be more effective for the person with mental illness, but also would allow cost control by the MCO (Bazelon, 1995, 1998; Petrila, 1995, 1998).

Interviews with Experts and Stakeholder Groups

A number of individuals and organizations with expertise in mental health law and policy were asked to participate in a semi-structured telephone interview on the relationship between Medicaid managed care and court-ordered treatment. Eight of the individuals or groups contacted agreed to be interviewed; others declined, indicating knowledge of either managed care or court-ordered treatment, but not both. With the respondents’ permission, the interviews were tape-recorded and transcribed for thematic analysis. In addition, these individuals commented on the draft literature review, providing additional sources of information or commenting on the literature review’s representation of the issues. Their feedback has been incorporated into this report.

Interviews with State Representatives

This component of the project was to identify a number of States’ approaches to designing Medicaid managed care plans and, in particular, to addressing issues related to civil commitment within those plans. A primary source for this effort was the most extensive existing review of Medicaid managed care contracts available—a three-volume compendium produced by the Center for Health

Policy Research at George Washington University (GWU). Sara Rosenbaum and her colleagues at GWU reviewed 54 Medicaid managed care contracts, at least 12 of which were designed specifically for managed behavioral health care (Rosenbaum, Smith, Shin, et al., 1997). The three-volume set offers detailed information on diverse aspects of the contracts, such as enrollment procedures, coverage and benefits, definitions of medical necessity, quality assurance data reporting requirements, and provisions related to court-ordered commitment.

Based on information contained in this seminal GWU review and on the recommendations of interviewees, nine States were identified as targets for participation in the evaluation of the relationship between Medicaid managed care and involuntary treatment. Seven of the States—Arizona, Florida, Iowa, Massachusetts, Minnesota, Utah, and Wisconsin—were identified as potentially having language in their managed care contracts that addressed the issue of court-ordered commitment. Two additional States—Maryland and Colorado—were selected specifically because their contracts did not appear to contain provisions regarding court-ordered services in the managed care environment.

For each of these nine States, in-depth telephone interviews were conducted with an average of three individuals per State. The interviewees were selected from the ranks of State policymakers (at the Medicaid agency, the State Mental Health Authority [SMHA], or both), consumer advocates, family members, providers, and MCO representatives. Respondents were asked their perceptions of Medicaid managed care, civil commitment, and possible connections between the two. For those interviewees representing either the State

Medicaid Agency or SMHA, specific questions related to managed care contract language and its development were asked,⁹ such as: Was the contract language identified in the GWU report still current?¹⁰ If so, how had that contract been developed? If not, what had led to the changes? Had the incidence of civil commitment changed since Medicaid managed care had been instituted in the State? Did the contract clearly specify the relationship between the courts and the MCO? How were recent experiences in the State informing development of future contract language? With the respondents' permission, interviews were tape-recorded and transcribed. These transcripts were shared with nearly all respondents to verify the accuracy of the information and permit additional insights.

Case Studies

Although some information was gathered in each of the nine States about the Medicaid managed care contract provisions for civil commitment, in-depth case studies were developed only for Wisconsin, Colorado,

¹⁰ Several respondents reported that contract language used by the study team was not current. For example, Colorado did have specific contract language for court-ordered commitment, whereas Utah did not. Contracts had either been modified or were in the process of being rewritten, often because some of the policy issues discussed later in this report had emerged as troublesome for the State. In addition, there may have been an issue of what contract documents were reviewed; for example, many States incorporate the request for proposals (RFP) in their contracts by reference. It was not clear that all RFPs had been reviewed for the GWU study. Thus, while reviews such as the one conducted by the Center for Health Policy at GWU offer policy analysts an extensive array of information, the rapid rate at which public health systems are undergoing change limits the usefulness of such reports. This is offered not as a criticism of the efforts of the authors, but rather as a caveat for other analysts who are using similar sources of information.

Iowa, and Minnesota. These four were selected based on the comprehensive information provided by interviewees. That information included any administrative data related to civil commitment or inpatient hospitalization, interviewees' participation in the development of the current contract language, as well as their ability to recall experiences that shaped the current contract provisions. In addition, Iowa and Colorado were selected because their original Medicaid managed care contracts explicitly addressed an array of issues that might affect civil commitment; Wisconsin was selected because of its more limited provisions. Minnesota was selected because the Medicaid managed care contract incorporated specific provisions only after initial implementation, following the consequences of the initial failure to address the issue.

Study Limitations

The reader should be aware of several limitations in both this study and its findings. First, only the issue of civil commitment under Medicaid managed behavioral health care contracts is addressed. Consumers' experiences with private-sector managed care companies and civil commitment undoubtedly may vary from the accounts described herein. Thus, the findings reported here cannot be generalized to either private managed care for behavioral health services or any other form of managed care financing.

Second, almost no quantitative data was available that specifically documented the incidence of civil commitment, under either Medicaid fee-for-service or managed care in the nine States. Although indicators, such as number of hospital admissions, lengths of stay, and re-admission in a 6-month period were collected in most locales, only Colorado was able to provide longitudinal data on the

frequency with which behavioral health consumers were court-ordered to receive treatment. Thus, findings are based largely on anecdotal information and on data related to inpatient care—a tenuous proxy for court-mandated services.

In addition, few individuals appeared to be aware of a relationship between Medicaid managed care contracts and the incidence of civil commitment. That was as true of expert interviewees as it was for many of our State stakeholder contacts. In fact, awareness of trends in the incidence of civil commitment may be limited to a few select stakeholders in any system—particular judges or individuals in charge of prepetition screening. Such particularly expert State-level key informants were not always readily identified or accessible. Thus, each State overview is related, in part, to the capacity to reach and interview these key informants within the time constraints of this study.

Finally, this report does not specifically address issues related to *outpatient* commitment within a Medicaid managed care framework. As with civil commitment to inpatient settings, interviewees offered few anecdotes, and no State was able to provide quantitative data on outpatient commitment. Moreover, the concept of “outpatient commitment” is subject to tremendous variability across jurisdictions: some States define it as “trial release” from an inpatient setting; others have established an outpatient commitment procedure by discrete legislation. Given the complexity of the issue and the fact that other mental health services researchers are exploring this topic,¹¹ thorough exploration of the relationship between Medicaid managed care and outpatient commitment is beyond the scope of this project.

¹¹ William Fisher at the University of Massachusetts Medical School reportedly is examining data related to this issue.

IV Summary Findings from Case Studies

This chapter presents findings from the four case study States—Wisconsin, Colorado, Iowa, and Minnesota. These States were selected based on the relative comprehensiveness of information elicited from interviewees. This level of detail included verification of the State profiles from the Substance Abuse and Mental Health Services Administration (SAMHSA) “Managed Care Tracking System” Web site; administrative data about civil commitment or inpatient hospitalization; and interviewee participation in the development of current contract language, as well as their recall of experiences that shaped the current contract provisions. In addition, States selected had different experiences in developing contract provisions (highlighted in Table 1).

The brief summaries that follow describe the relevant contract provisions in each of the four States. More detailed descriptions of contract development and stakeholder perspectives can be found in the expanded case study presentations in the Appendix.

Iowa Medicaid Managed Care Contract and Civil Commitment

In March 1995, Iowa received the 1915b waiver that allowed the State to create the Mental Health Access Plan and the Managed Substance Abuse Care Plan. Since January 1999, these two plans have been combined into a single behavioral health carve-out, the Iowa Plan for Behavioral Health. The current plan’s contract with one for-profit company, Merit Behavioral Care of Iowa, serves the entire State.

The Iowa contract indicates a number of provisions that address civil commitment

under Medicaid managed care. While the issue was addressed under the two 1995 carve-outs, the current plan’s provisions are even more detailed and comprehensive. Under the 1999 contract, court-ordered inpatient treatment may occur in a community-based hospital or in a State psychiatric hospital. The contractor must pay for all court-ordered services provided in a community-based hospital and that fall within the contractor’s utilization review guidelines. Institution for mental disease (IMD) treatment costs are the responsibility of the counties. To prevent the managed care organization (MCO) from shifting treatment costs to the counties, total county expenditures for IMD care were capped at pre-managed care levels. Any excess costs must be assumed by the MCO.

The contractor and State officials concluded that the traditional definition of “medical

necessity” was too narrow to address the needs of the enrolled population. They agreed to expand the definition to one of “psychosocial necessity.” Under this definition, treatment decisions must take into consideration the enrollee’s clinical history, the potential for services/supports to avert the need for more intensive treatment, and any unique circumstances that may make particular services inaccessible or inappropriate for an enrollee (e.g., availability of transportation, absence of natural supports). The MCO also is required to employ two court liaisons to educate and coordinate service planning with judges.

The contract specifically requires coverage for certain community support services, such as Intensive Psychiatric Rehabilitation, Assertive Community Treatment, mobile crisis and counseling, peer support services, and supported community-living. Interviewees reported significant enhancements to the community support system under the Iowa Plan. Novel approaches included creation of crisis centers and outreach teams, the use of telemedicine in rural areas, and even the use of funds to help severely disabled consumers acquire needed household items. The contract includes 40 different measures, some with financial incentives, to foster desired

Table 1. Contractual Provisions for Civil Commitment under Medicaid Managed Care

	<i>Provision for MCO to pay for court-ordered services</i>	<i>Provision to address IMD treatment costs</i>	<i>“Medical necessity” definition re-fined to address population</i>	<i>Coordination between MCO and the courts</i>	<i>Enhancement of community-based support services</i>
IOWA	MCO covers all court-ordered services that are within its utilization review guidelines	MCO assumes any excess of baseline est’d prior to managed care	Definition expanded as “psychosocial necessity”	Two court liaisons employed by MCO	MCO est’d community reinvestment fund; ACT, IPR, other services are covered
COLORADO	MCO covers the cost of all court-ordered services, without exception	MCO assumes IMD costs if allocated State-funded beds are full	Broad definition; requires services for anyone with a covered diagnosis	Contractor is “encouraged” to work with the judiciary	Specific services required, others “expected”; no reinvestment requirements for enrolled pop’n
MINNESOTA	MCO cannot deny payment on the basis of “legal-not-medical” decision	MCO can use IMD beds, but must assume the costs without using Medicaid funds	MCO criteria cannot be more stringent than the Minnesota standard	Counties must allow MCO to participate in treatment decision if MCO is to pay	Not addressed in contract
WISCONSIN	MCO covers all civilly committed enrollees, except Chapter 980 persons (sexual offenders)	IMD exclusion not addressed	Standard Medicaid “medical model” definition used	Some education of judges by MCO representatives	Certain community services covered, but are not required to be offered

MCO = managed care organization; IMD = institution for mental disease; ACT = Assertive Community Treatment; IPR = Intensive Psychiatric Rehabilitation.

performance. One of these measures monitors the balance between community-based and inpatient treatment. All of these efforts—including the contractor’s establishment of a community reinvestment fund—reportedly have reduced the need for court interventions as well as for expensive inpatient treatment.

The provisions and incentives in the most recent Iowa contract aim to limit the use of court orders for individuals who have a mental illness. None of the interviewees reported observing a noticeable change in the use of civil commitment. Stakeholder representatives anticipated no imminent contractual changes.

Colorado Medicaid Managed Care Contract and Civil Commitment

In 1995, Colorado received a Section 1915b waiver for a Medicaid mental health carve-out, the Mental Health Capitation and Managed Care Program. Enrollment in the statewide program is mandatory for all adults and children who are eligible for Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), who receive Supplemental Security Income, or who are dually eligible. Enrollee services’ costs are managed by one of eight contractors (known as Mental Health Assessment and Service Agencies [MHASAs]) that are at full financial risk. The terms of this waiver were renewed in 1998 and expired in March 2000.

In the request for proposals (RFPs), included in the Colorado Medicaid managed care contract by reference, the contractors’ responsibility for civilly committed enrollees is well defined. The MHASA must provide all mental health services ordered by a court, without exception, even if it does not believe

the services are necessary. To manage its risk, the contractor is encouraged to work with the judiciary and clinicians to determine the most appropriate level of care for each individual.

This encompassing mandate notwithstanding, the Medicaid IMD exclusion appears to offer the contractor one possible way to shift responsibility for high-cost enrollees to the State Mental Health Authority (SMHA). To preclude this possibility, each MHASA is allocated a fixed number of State hospital beds, the costs of which are assumed by the SMHA. If an enrollee requires inpatient services and allocated beds are full, the MHASA is responsible for the cost of the enrollee’s inpatient treatment, wherever it occurs.

“Medical necessity” has also been broadly defined in the Colorado contract to reduce the contractor’s ability to deny payment for costly services. Under the terms of the agreement, “the contractor shall provide all mental health services necessary to treat a diagnosis that is included in the Mental Health Capitation and Managed Care Program.”¹² The contractor, thus, is compelled to treat an enrollee whom the court determines has a mental illness. The only contractor decisions pertain to the level of care deemed appropriate to address the individual’s diagnosis.

The 1997 RFP required that services based in the community, such as partial-day programs and psychosocial rehabilitation programs, are available to enrollees on the first day of the contract. The contractor also was “expected” to offer such nontraditional services as respite care, consumer drop-in centers, “warm lines” (peer-run phone lines,

¹²Diagnoses not covered include substance abuse, alcoholism, mental retardation, and organic brain syndrome.

on which a concerned consumer can call another consumer to discuss issues), early intervention services, peer counseling, and other support services. The contract has no reinvestment requirements aimed at enhancing community supports for the Medicaid-eligible population. However, the State has realized significant expansion in community mental health services by reducing reliance on inpatient services (GAO, 1999). In fiscal year 1994–95 approximately half (50.6%) of the State’s mental health resources were spent on inpatient services. One year after the implementation of the mental health carve-out, inpatient services used only 17.2 percent of the budget; all other services received 82.8 percent of the resources (“Colorado Mental Health Capitation Pilot Program Final Report,” p. 3). Interviewees regarded this development of strong community-based services as critical to reduction of civil commitment of individuals with mental illness to inpatient settings.

Interviewees reported observing no increase in the use of civil commitment under the Medicaid managed mental health plan, a finding consistent with the State’s concerted effort to reduce the contractors’ incentive to use civil commitment procedures. No changes currently are anticipated in the next round of contracting for the mental health carve-out plan in Colorado.

Minnesota Medicaid Managed Care Contract and Civil Commitment

In 1985, the Health Care Financing Administration approved the Minnesota Prepaid Medical Assistance Program (PMAP), a three-county demonstration project that used prepaid managed care plans to deliver health services to certain Medicaid enrollees, including families with children

and the elderly. In 1995 under a 1115 waiver, the PMAP was extended to 27 counties in the State. The State is currently developing a five-county Demonstration Project for People with Disabilities, a long-term managed care plan featuring a behavioral health carve-out that is scheduled to be implemented in July 2000.

In the original PMAP contract, fiscal responsibility for a civilly committed enrollee was not addressed. This oversight reportedly resulted in a difficult relationship between the contracting parties. The SMHA and the counties, for example, believed that the contractors were using various mechanisms (including the IMD exclusion and private insurance law provisions) to shift responsibility for high-cost clients to the State and counties. Conversely, the health plans complained that they were not being notified when commitment petitions were filed for their enrollees. Because they had no input into an enrollee’s treatment plan, the contractors said, they had little opportunity to actually manage the costs of care.

In recent years, several statutes have been adopted in an effort to clearly delineate the parties’ roles and responsibilities for civilly committed enrollees. First, through the 1995 1115 waiver, a new PMAP contract provision allowed the health plan to use IMD services for enrollees only if the plan assumed fiscal responsibility for those services. The provision’s goal was to eliminate the IMD exclusion as a cost-shifting mechanism. In addition, two statutes were enacted to clarify the definition and determination of “medical necessity.” In 1997, the Minnesota legislature adopted a minimum statewide definition of medical necessity for mental health services, criteria that could not be overridden by a Medicaid

contractor's more stringent parameters. Legislation was also adopted in 1999 that prevented a health plan from denying the medical necessity of treatment simply because it was ordered by a court of law.¹³ This provision does not require the contractors to pay for *all* court-ordered services, but does prohibit them from refusing to pay for treatment simply on the basis that the court ordered it. A final statute was adopted in 1999 requiring the counties to seek health plan input during the prepetition screening process. The overall result of these amendments has been to minimize opportunities for cost-shifting to ensure effective cost management by the contractor, and, ultimately, to ensure that individuals in Minnesota with a mental illness receive the appropriate level of care.

Stakeholders suggested that the incidence of commitment orders has steadily increased since implementation of the original PMAP contract. The probable cause of the apparent trend, however, is open to question. Some providers and consumer advocates believe the increase to have resulted from Medicaid managed care. Representatives from the SMHA, however, noted that the effects of a number of contemporaneous policy changes in the State cannot be isolated. The absence of valid quantitative data on the frequency of civil commitments, combined with the simultaneous implementation of multiple policy changes, makes it impossible to determine with accuracy how Medicaid managed care has affected the use of civil commitment in this State. What is clear is that the experi-

ences with the PMAP contract have clarified the health plans' responsibility for enrollees who are civilly committed. These contract provisions reportedly will be extended to the Demonstration Project for People with Disabilities.

Wisconsin Medicaid Managed Care Contract and Civil Commitment

Wisconsin's Medicaid HMO program is an integrated plan, implemented statewide in 1994 under a Section 1915b waiver. Under the terms of the plan, the State Medicaid agency contracts with 19 health maintenance organizations (HMOs) that receive full capitation payments for all medical services covered by Medicaid.¹⁴ Wisconsin also received a 1115 waiver in 1998 to implement BadgerCare, a statewide integrated plan serving uninsured and underinsured families. Enrollment in either plan is mandatory for all qualifying adults, children, and families. Five additional Medicaid managed care plans in the State target specific subpopulations of Medicaid eligibles. Enrollment in any of these five is voluntary.

Despite enrollee and administrative variations, interviewees reported that civil commitment-related provisions of the different contracts are identical. In each plan, mental health services incorporated into the capitation rate include inpatient care, IMD services for individuals under 21, crisis services, mental health support (e.g., community support programs, targeted case management), pharmacy services, rehabilitation services, residential care (e.g., in-home therapy), and outpatient services. In addition, all MCOs must assume financial responsibility for civilly committed enrollees; they cannot

¹³ A provision in private insurance law allows insurers to automatically deny payment for services provided on the basis of a legal decision. Some MCOs have carried this practice into the Medicaid managed care contract and applied the provision to civil commitment orders.

¹⁴ Two noted exceptions are prenatal care coordination and common carrier transportation.

refuse to pay for court-mandated treatment simply because it was ordered by a court of law. The one exception to this mandate is the recently passed Chapter 980 legislation, requiring sexual offenders to be committed indefinitely to an inpatient mental health facility following their prison sentences. By law, treatment costs associated with these individuals are the State's responsibility.

Because the Medicaid IMD exclusion is not mentioned in any of the contracts, an MCO in Wisconsin is not required to assume any responsibility for adult IMD care. Although this creates an incentive for the contractor to civilly commit enrollees to a State psychiatric hospital, interviewees did not observe any change in the use of civil commitment in the system.

The definition of "medical necessity" was reported to be a point of contention between managed care contractors and State agency representatives. Although many States have made significant changes to the definition to

avoid interpretive complications, Wisconsin opted to use a standard Medicaid "medical model" definition for the covered population. Interviewees reported significant conflict in this area, particularly since the narrow definition afforded MCOs significant latitude to deny payment.

The Wisconsin Medicaid managed care contracts specify the types of community-based services covered under the plans, but they do not state explicitly that the MCO must make these services available to enrollees. Perhaps not coincidentally, community support systems in Wisconsin were described as having limited service capacity; Community Support Program waiting lists extend up to 3 years. However, interviewees drew no connection between contract provisions and waiting lists, nor did they report any apparent effect on the civil commitment use in Wisconsin. No significant changes were anticipated in any of the Wisconsin Medicaid managed care contracts.

V. Conclusions

This report has examined how different States address civil commitment in their Medicaid managed care contracts, and the impact contract language has on the frequency of or manner in which civil commitment is used. In the previous chapter, four States were examined in some detail, looking not only at the contract provisions specific to civil commitment, but also the specific experiences that led to adoption of those provisions. These jurisdictions differed in their Medicaid managed care financing arrangements, the structure of the civil commitment process, and the content of specific contract provisions. Given the variability in each element and the speculative nature of much of the material, caution clearly is warranted in reaching conclusions. The following particular themes did emerge across the study sites, however, suggesting issues relevant to civil commitment that should be addressed in Medicaid managed behavioral health care contracts:

- Contracts that do not address the issue of fiscal responsibility for costs associated with civil commitment may result in increased use of court-ordered treatment. The absence of clear contract provisions may create incentives for managed care organizations (MCOs) to use civil commitment as a way to shift costs onto the State mental health authority or counties. Some MCOs will rely on principles of private insurance law to automatically deny the medical necessity of court-ordered services; others may rely on the Medicaid institution for mental disease (IMD) exclusion to deny payment for court-ordered services in State hospitals. Contracts that anticipate such potential cost-shifting possibilities and address them may prevent growth in the frequency of civil commitment in a system.
- Collaboration between the judiciary and the MCO may reduce the incidence of court orders to inpatient settings. Many judges, with limited knowledge of treatment options within the community, may routinely order civilly committed individuals to inpatient settings. Communication between the courts and MCOs often results in treatment in less restrictive settings and allows the MCO to better manage treatment costs.
- Systems that restrict access to services excessively may increase use of civil commitment as a means of obtaining treatment. Potentially restrictive policies include narrow “medical model” definitions of medical necessity that leave MCOs too much latitude to deny payment for services required for persons with serious mental illness. Medicaid

managed care contracts can address treatment accessibility so needed services can be obtained without resort to court orders.

- A comprehensive system of supports based in the community may reduce the need for civil commitment. The types of supportive services needed to help an individual maintain stable functioning in a community setting are well established, but are not always included in Medicaid managed behavioral health care programs (or Medicaid fee-for-service programs for that matter). Contracts that require MCOs to develop strong community supports may result in greater responsiveness to consumers' needs, thereby reducing the need for civil commitment.

Mandating MCO Responsibility for Some Civil Commitment Costs

The importance of including contract provisions to eliminate MCOs' blanket refusal to pay for any court-ordered services is a key theme that emerged across all study sites. Three of the four States in the case studies incorporated such provisions near the beginning of the Medicaid managed care contracting process. The fourth State, Minnesota, drafted such provisions after perceiving the absence of such provisions had created adverse consequences for the State's mental health consumers. Although State contracts varied in nomenclature and scope, apparent consensus across jurisdictions was reached that MCOs must bear some responsibility for the costs of court-mandated treatment for enrollees. In the absence of relevant contract language, persons with mental illness may find themselves disenrolled from their managed care plan as a result of the civil

commitment process, disrupting the individual's tenure in the community and cost-shifting payment to the State, all of which effectively defeats the intention of a Medicaid managed care arrangement.

Requiring MCO Involvement with the Courts and the Civil Commitment Process

A major concern with the typical operation of the civil commitment process is that the judge, having determined a person meets the criteria for involuntary civil commitment, routinely places the individual in an inpatient setting, such as a State psychiatric hospital. In addition, the commitment often is for a fixed period that may be longer than is clinically appropriate. Such standard commitment orders sometimes ignore both the legal requirement that placement be in the "least restrictive alternative" setting and the individual differences in the duration of needed care. Historically, many communities have lacked appropriate alternative care settings; judges may not be aware of those that do exist. Moreover, judges are not attentive at all times to the fiscal impact of their decisions on service providers or MCOs. The result is that consumers may be routinely ordered to State psychiatric hospitals for fixed periods, rather than to alternative settings that may well be less restrictive and provide a more appropriate level of care.

Several of the States in this study have attempted to control clinically inappropriate inpatient utilization by including contract language that requires the MCOs to engage actively in the commitment process and to provide information about appropriate care alternatives to the judges. In some cases, the MCO is specifically required to evaluate a client within a specified period of time so a suitable plan of care can be formulated and

communicated to the judge. The MCO's responsibility in the process has been most clearly delineated in Iowa, where the contract requires the MCO to hire two court liaisons to work full-time with the judges. Other States have adopted similar, if less stringent, provisions "encouraging" the MCO to coordinate with the judges in the civil commitment process (Colorado) or requiring counties to consult with the MCO at prepetition screening (Minnesota). Such collaborations hold the potential to help ensure appropriate levels of care in less restrictive settings, while allowing the MCOs some control over costs.

Preventing the Use of Civil Commitment to Shift Responsibility for Clients and Costs

In many Medicaid managed care arrangements, the responsibility for high-cost treatment services can be shifted from the MCO to another part of the system. As noted earlier, one opportunity for cost-shifting is created by the Medicaid IMD exclusion, which forbids Medicaid funds to pay for IMD services for adults ages 22 to 64. In some of the States in the study, interviewees reported that the majority of court orders for treatment were made to State hospitals. In cases in which States failed to address this issue in their Medicaid managed care contracts, MCOs may have used court orders to shift responsibility for high-cost clients to the State Mental Health Authority or the counties. An interviewee from Minnesota stated:

For involuntary treatment this year the Legislature passed a law that...health plans can be deemed responsible for court ordered treatment that is medically necessary....Prior to that we've always had the concern...that health plans could use an IMD setting as a cost-shift from their...financial respon-

sibility to the State....We don't have the data that shows this would happen...nobody admits to it, but everybody suspects that that was probably a motivator in at least some of the cases.

The IMD exclusion offers the most obvious opportunity for cost-shifting through the use of civil commitment orders. States that anticipated such a trend either adopted legislation or redrafted their contracts to address this matter.

Our interviewees also noted that the Medicaid statute prohibits payment for services delivered to persons in the correctional system, offering another venue to which the MCO may shift responsibility for high-cost individuals. Many interviewees commented that, while inpatient mental health care is decreasing, the number of behavioral health consumers being placed in other institutional settings, such as the corrections system, appears to be on the rise.¹⁵ In one Colorado county detention center, for example, the number of beds had risen from 80 to 550 over the past two decades,¹⁶ with one wing of the facility now devoted exclusively to serving individuals with "significant mental health problems." In response to the increase in the numbers of people with mental health problems, the detention center has contracted out for a psychologist and has hired four full-time psychiatric case managers to assist these clients.

¹⁵This viewpoint is consistent with other research on the relationship between the mental health and corrections systems (Steadman, Morris, & Dennis, 1995; Lamb & Weinberger, 1998).

¹⁶The population increase for the county over the same period has been only about 50 percent (from 140,000 residents to a little over 200,000). Thus, the detention center capacity increased at a rate disproportionate to the population expansion in the county.

Certainly, while fiscal division between these two systems might suggest an opportunity for cost-shifting from an MCO to the correctional system, the extent to which this actually happens is unclear. Nevertheless, officials responsible for a Medicaid managed care program need to be cognizant of the potential for cost-shifting to correctional systems. At the very least, a Medicaid managed care contract should encourage coordination among service agencies to ensure that consumers receive the type and level of services most appropriate to their needs.

Precluding the Use of Civil Commitment to Obtain Needed Services

Much of the debate around civil commitment centers on the ethics of forcing people with mental illness to receive unwanted treatment. Those favoring court-mandated treatment argue that society has a responsibility to provide treatment to a person incompetent to make a decision on his or her own behalf. In contrast, other consumers with mental illness should have the same right to refuse treatment as other people with defined illnesses. Ultimately, both sides focus on the relationship between the commitment process and the civil rights of the individual.

Less frequently discussed, but certainly an issue raised by interviewees, is the use of civil commitment to override structural barriers to care. For example, interviewees in Minnesota noted that past State-level policies designed to limit the use of costly treatments had inadvertently encouraged the use of civil commitment as a way to gain access to services such as inpatient hospitalization.

The advent of Medicaid managed care raised similar concerns. Specifically, several interviewees noted that if a contract fails to define the criteria for and process of deter-

mining “medically necessary care” explicitly, MCOs might deny coverage for expensive services, such as inpatient care. Families and providers are left little choice but to use the courts to provide consumers with denied-but-needed treatment. Thus, several States in this study adopted contract provisions designed to prevent just this use of the civil commitment process. In Iowa, for example, the contractor readily agreed to pay for a 5-day evaluation period specifically to discourage stakeholders from believing that courts are the only way to access services.

Other States recognized that vaguely defined criteria for “medical necessity” provided the same potential for denied treatment and use of the courts to access services. In Minnesota, the original Medicaid managed care contract did not address the issue of medical necessity, leading stakeholders to speculate that MCOs were routinely denying specific high-cost treatments for enrollees. As a result, legislation was passed to define minimum standards of “medical necessity” clearly, so access to services would no longer be an issue. Conversely, Colorado policymakers believed that if they kept the contractual definition of medical necessity deliberately vague, they could limit the basis on which the MCO could deny treatment. Recall from the Colorado case study that once an evaluation determines that an individual has a mental illness, the contractor is required to “provide all mental health services necessary to treat a diagnosis.” Thus, by the terms of the contract, the MCO cannot refuse to pay for treatment in general, but does have an opportunity to determine with the courts what particular treatment would best serve the consumer.

Skeptics sometimes suggest that a more appropriate appellation for “managed care”

is “managed costs.” They are concerned that MCOs may refuse to pay for certain services routinely in an effort to enhance profits. Stakeholders have been concerned that under such a scenario, desperate measures—such as civil commitment—would be required to obtain high-cost services for consumers. Several States have anticipated such difficulties and have included language in their Medicaid managed care contract to prevent them.

Reducing Civil Commitment by Enhancing Community Support Systems

Many of the stakeholders interviewed agreed that a well-developed system of services within the community can reduce dependence on inpatient hospitalization, a viewpoint that has long received support from consumer advocates and others in the field (AMBHA, 1998; Blanch, 1992). With the advent of managed care, however, the concern has arisen that MCOs might fail to develop an adequate community support structure in an effort to realize short-term cost savings. Chris Koyanagi of the Bazelon Center discussed this perspective:

With those [managed care] companies, the concern was they will find the cheapest way to provide services...one of the cheapest ways to provide services is not to work with someone and help them understand their illness and provide 24-hour case management while they go through the various crises. The simple way would be to just slap a commitment order on them and get them in the hospital, get them on the drugs you think are going to work.

Although a managed care arrangement may lead to poor community support and an increase in civil commitments to inpatient settings, this outcome is not inevitable.

Indeed, several study States have made a concerted effort to enhance services within the community precisely to reduce civil commitment and inpatient hospitalization. In Iowa, for example, the MCO has been given wide latitude in determining what services can be covered under the terms of the contract. The representative from Merit Behavioral Care of Iowa stated,

The State’s goal when they went to managed care is that by...not...having to only pay for traditional kinds of services...with those dollars we could be much more flexible. And through that flexibility, what they were really hoping is that we could reduce inpatient stays. So that we could use those dollars and pay for support services...in the community, in a person’s home.

In addition to allowing this flexibility, Iowa’s managed care contract indirectly promotes development of alternative services within the community through the use of performance indicators and financial incentives. For example, if the benchmark for Community Tenure is met (“the average time between hospitalizations shall not fall below 60 days”), the contractor receives a financial reward of \$125,000. With such an incentive, it is in the contractor’s financial interest to create a community support system to prevent consumers from being returned to the hospital through civil commitment proceedings.

Other States have more direct provisions detailing a contractor’s responsibility for enhancing community support. In Colorado, for example, the contract explicitly requires that certain services within the community, such as psychosocial rehabilitation programs and partial-day programs, be in place at the beginning of the contract period. Other innovative community supports, such as peer

counseling and warm lines, are “encouraged” under the terms of the contract.

In the absence of contract provisions to ensure the availability of adequate community supports, the incidence of civil commitment could increase under Medicaid managed care. The foregoing examples illustrate that community supports can be preserved and even enhanced under a Medicaid managed care contract. Explicit inclusion of such provisions may ultimately reduce the system’s reliance on civil commitment within the managed care framework.

Areas for Further Study

Throughout this study, interviewees offered interesting perspectives about the relationship between Medicaid managed care and civil commitment, some beyond the intended scope of this project. The first and most important of these is that the ability to draw conclusions about the relationship between Medicaid managed care and the civil commitment process is limited by the dearth of quantitative data from the study sites. Most interviewees acknowledged that they could “only guess” about trends over time or whether the shift to Medicaid managed care had had an impact on the commitment process. Although Colorado was able to provide detailed information about court orders under managed care, the absence of baseline data (i.e., pre-Medicaid managed care) makes these data virtually impossible to assess. Only with valid and reliable longitudinal data will researchers be able to identify trends and attempt to understand the impetus behind them.

Second, and of apparently growing significance, many of our interviewees expressed concern about the increasing number of individuals with serious mental illness who are

ending up in correctional facilities. Although Medicaid managed care was not seen as the cause of this movement, additional research might explore the extent to which managed care potentially can exacerbate or forestall this trend. For example, policy expert John Petrila has suggested that research be conducted on the impact of mental health courts, which aim to move people with mental illness to more appropriate treatment settings than jail. Not only has such a court been established in Broward County, Florida, but two bills also have been introduced to Congress (H.R. 2594: Rep. Strickland (D-OH), and S. 1865: Sens. DeWine (R-OH) and Domenici (R-NM)) that propose the funding of up to 25 demonstration mental health courts. Given the widely divergent mandates of the judiciary (protecting society) and the managed care contractors (cost-efficient mental health interventions), evaluation of these demonstration projects might explore the extent to which a collaborative relationship can be established between the two institutions. For example, would a court liaison (as is currently being used in Iowa) be effective in such a potentially adversarial setting? How much say would the consumer have in his or her placement decision? And in order to preclude cost-shifting, what contract language could be developed to clarify the MCO’s fiscal responsibility if an enrollee were incarcerated? Related studies might involve comparing clinical outcomes and criminal recidivism rates for diverted versus nondiverted individuals, staff attitudes toward the patients/inmates in the clinical and correctional settings, and the extent to which the mentally ill persons see such court actions as coercive or beneficial.

A final issue raised by many mental health consumers and advocates is how the

frequency of civil commitments may be affected by the use of “advance directives,” that is, consumer-developed documents that specify the services the individual is to receive in the event of a psychiatric emergency (Bazelon Center, 1999). Will the judiciary and the MCO accept the advance directives? Will doctors legally be able to carry out the directives? Can the advance directives be used as an alternative to court-ordered care? While one of our interviewees suggested that advance directives could effectively reduce the number of civil commitments, future studies might focus on the experiences with advanced directives and the implications both for managed care and the civil commitment process.

VI. References

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VII. Appendix

This Appendix includes case studies for four of the nine States originally selected for this project. These four—Wisconsin, Colorado, Iowa, and Minnesota—were selected on the basis of the level of detailed information able to be obtained at each of the sites. This information included State profiles from the Substance Abuse and Mental Health Services Administration (SAMHSA) “Managed Care Tracking System” Web site, administrative data related to civil commitment or inpatient hospitalization, interviewees’ participation in the development of the current contract language, and interviewees’ ability to recall experiences that shaped the current contract provisions. In addition, we attempted to select States that had different experiences around the development of contract provisions. Thus, Iowa and Colorado were selected because their original Medicaid managed care contracts explicitly addressed the array of issues that might affect civil commitment. Wisconsin, by contrast, was selected because civil commitment is addressed in its contract, but in a more limited fashion than either Iowa or Colorado. And, finally, Minnesota was selected because specific provisions were adopted in its contract only after concerns had been raised about how civil commitment was being used within the Medicaid managed care framework. A synthesis of the findings from these four case studies is included in Chapter IV.

Case Study A

Wisconsin Medicaid Managed Care Contract and Civil Commitment

Background

Wisconsin’s Medicaid health maintenance organization (HMO) program was implemented statewide in September 1994 under a Section 1915b waiver. The Medicaid HMO program is an integrated plan that covers physical health as well as acute mental health and substance abuse services. Enrollment is mandatory for all adults and

children who are in any of the following categories: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/TANF); pregnant women and children up to 165 percent of the Federal poverty level (Healthy Start); and those dually eligible for Medicaid and Medicare. Under the terms of this plan, Medicaid contracts with 19 HMOs licensed by the State of Wisconsin. The HMOs receive a full capitation payment for all medical services covered by Medicaid.¹⁷

¹⁷Two noted exceptions are prenatal care coordination and common carrier transportation.

Capitation rates vary by region and there are 10 rate regions across the State.

In addition to the HMO program, there are six other managed behavioral health care plans in the State, each of which covers a specific subpopulation and has a different administrative arrangement. For example, under a 1115 waiver, the State implemented BadgerCare in 1998, a statewide integrated plan that serves uninsured and underinsured families. Enrollment in this plan is mandatory for qualifying families. The five remaining Medicaid plans are all voluntary enrollment and include two behavioral health stand-alones (Children Come First and WrapAround Milwaukee, which serve children with severe emotional disturbance in Dane County and Milwaukee County, respectively) and three integrated plans (Independent Care and the Wisconsin Partnership Program, both of which cover acute behavioral health services to the Supplemental Security Income [SSI] population, and the Program for All Inclusive Care for the Elderly, which covers acute behavioral health services for frail elderly persons).

Despite enrollee and administrative variations, the provisions of the different contracts are the same. Specifically, in each plan, the mental health services incorporated into the capitation rate include inpatient care, IMD services for individuals under 21, crisis services, mental health support (e.g., community support programs, targeted case management), pharmacy services, rehabilitation services, residential care (e.g., in-home therapy), and outpatient services.

Has the State addressed civil commitment in its managed care contract?

All of the contracts in Wisconsin require that the MCO pay for any enrollee who is court committed to treatment. The State Medicaid

representative noted that the primary rationale for including this contract provision was to avoid the development of divided funding streams:

When we moved from a county-based system to a managed care system, we expected the managed care agency to take over at the same cost as the county, so...we do require that commitment or court services are paid for by the HMO....When we made the switch in funding, the intent was that all of the services be provided under the managed care [plan]. It was one total package, it was not broken up or funding left in certain places.

Does the contract clearly specify whether and under which circumstances the MCO is responsible to pay for court-ordered (services)? What was the rationale for including this provision?

Two key provisions are included in the Wisconsin Medicaid managed care contracts. First, as noted above, the MCO must pay for any court-ordered services (with one exception, which is discussed in greater detail below). Second, Article 3B12 of the contract specifies that payment cannot be denied because the treatment resulted from a “legal” or “administrative” decision rather than a medical one. This is an issue from commercial insurance law that has emerged as a potential loophole for MCOs in many of the States in our study. By including these explicit contract provisions, Wisconsin has reduced the MCOs’ potential perverse incentive to let consumers decompensate and be civilly committed to treatment.

Recent legislation in Wisconsin concerning sexual predators, however, has led to a marked increase in the number of individuals being civilly committed in the State. Under Chapter 980, sexual predators who have completed their prison sentences auto-

matically receive a civil commitment to an inpatient mental health facility for an indefinite length of time. The legislation was expected to affect between four and six people per year, although one interviewee reported that the Chapter 980 population is “already up close to 300.” The treatment costs associated with these court-committed consumers, however, are not the responsibility of the MCOs, but are picked up by the State.

Does the contract clearly specify where court-ordered hospitalization will take place and whether the MCO is responsible to pay for IMD care? If so, how is it addressed and what led to the adoption of the provision(s)?

The contract provisions do not specify where court-ordered treatment will take place, but do indicate that the MCO has to pay only for services delivered by in-network providers. Because judges do not always know which providers are in-network in a particular area, there have apparently been some difficulties. One of our interviewees said the following:

[The judges] are familiar with the civil commitment process...[but they are] less aware of how the payments occur. And there are a lot of issues around where a commitment is made....In some instances [the commitment is] to a facility that’s not covered by the particular HMO in the area. It causes some problems in the long run....If the provider is not in their network, [the HMO] is not required by law to pay for the services. So if a judge would commit an individual to a hospital, then the HMO has taken the position that they won’t pay for it...[and] the county ends up paying.

While the lack of information about network providers reportedly has “caused some real problems” throughout Wisconsin, the Medicaid IMD exclusion has been relatively unproblematic. Under the contract terms, the MCO is not responsible for IMD care for adults. When asked what would happen if a judge ordered a consumer into an IMD (such as a State hospital) for treatment, one respondent made the following reply:

Usually the courts don’t do that. If it was an adult court ordered in an IMD, I doubt that we would order the HMO to provide that service since it’s not a Medicaid covered service. But there would be nothing that would prevent the HMO from covering that service if they wanted to, because we do allow the HMOs to cover non-Medicaid services.

Although the HMOs had been given such permission, the respondent was unable to answer with any certainty the extent to which the HMOs have actually picked up IMD costs.

Regardless, the infrastructure in Wisconsin would seem to discourage the use of State hospitals as the loci for inpatient treatment. There are only two State facilities in Wisconsin, and they have only 750–800 beds between them. One respondent reported that forensics patients—many of whom, as noted earlier, fall under the Chapter 980 statute—take up most of these beds.

Thus, the issue around civil commitment and managed care coverage of inpatient treatment is related less to the IMD exclusion in Wisconsin than to the commitment of a person to a network provider. Interviewees report that education efforts are ongoing with judges throughout the State in an attempt to alleviate these difficulties.

Does the contract address issues related to what services will be deemed medically necessary and how this determination will occur? Why were the particular provisions adopted?

Under the Administrative Code for Wisconsin's Department of Human and Family Services (HFS 101.03) "medical necessity" is defined as "a medical assistance service...that is required to prevent, identify, or treat a recipient's illness, injury or disability." In addition, the service is required to meet such broad standards as being "consistent with the recipient's symptoms," "appropriate with regard to generally accepted standards of medical practice," and "of proven medical value or usefulness and...not experimental in nature." This standard definition of medical necessity is included in Wisconsin's Medicaid managed care contracts by reference to the administrative code.

None of the individuals interviewed described any difficulties around the determination of medical necessity with regard to a consumer's illness. In short, there was apparently little disagreement between the courts and the MCOs that consumers had a definable illness and, as such, were in need of treatment. More problematic has been determining the kinds of services that constitute "medical" interventions for this particular population. As representatives of other jurisdictions (e.g., Iowa) in this study have noted, the medical model of treatment—from which the above definition is derived—may not be appropriate with this population of consumers. Interviewees in Wisconsin remarked on the conceptual difficulties this issue creates between the courts and providers on the one hand and the MCOs on the other:

The community support program is a medical assistance service that can be

paid for [by the HMOs]. However, conceptually that's [a] problem that the HMOs have trouble dealing with because it's an area the State would consider more of a social service. And when we talk about case management they're talking about something entirely different, and we also have problems when we talk about outpatient services...[it's] a much different term than a medical group uses as outpatient.

In spite of this difference in meaning and the resulting problems, it was not anticipated that this definition would be refined or changed in any significant way.

The one modification that has been made concerned the MCO's fiscal responsibility for medically necessary outpatient services. Private insurance law allows insurers to place a dollar limit on how much outpatient treatment will be paid for under the terms of the contract. In Wisconsin, commercial insurance caps outpatient coverage at \$7,600 per year, whether or not the consumer is in need of further treatment. Because of potential "confusion" over the legal rights of commercial insurers versus Medicaid MCOs, the contract was rewritten to require the MCO to provide all services that were medically necessary, regardless of the cost of those treatments.

Does the contract require the types of community support services necessary to maintain client functioning? Are there other provisions intended to ensure the availability of adequate community supports?

The contract details the types of services within the community that are covered under the terms of the contract, but does not explicitly require the MCO to make those services available to enrollees. Some interviewees described community support sys-

tems in Wisconsin as having limited service capacity, which in turn may contribute to the civil commitment of some individuals to inpatient treatment:

In Dane County, the waiting list to get into a CSP [Community Support Program] is three years....When a person has to wait these long periods of time for a CSP or services, the mental health condition that they have may very well regress from lack of treatment or what they have to deal with in a community. They're not equipped to have the support they need to give them the coping skills, whatever they need to remain out here [in the community]. And then you have people going back and it's a continuous revolving door.

As with other areas of the contracts in Wisconsin, none of the respondents mentioned any future contractual changes regarding the role of the MCO in enhancing services within the community in the State.

Does the capitation rate include the cost of court-ordered services? Is there some form of incentive in the contract that would encourage the use of civil commitment?

With the exception of IMD expenses, the capitation payments to the MCOs include the cost of court-ordered services. Moreover, because the contract requires the MCO to pay for all court-ordered services, Wisconsin has reduced the incentive for the MCOs to use the civil commitment process as a way to shift high-cost consumers onto another payer. As noted above, some costs may be shifted inadvertently because of a judicial decision about the location of inpatient treatment. It appears, however, that such decisions are the result of judicial misinformation, rather than cost-shifting pressures from the MCO.

How do stakeholders believe these contract provisions (or lack thereof) have affected the use of civil commitment within each system?

All of the managed care contracts in Wisconsin contain a provision that requires the MCO to pay for court-ordered services. Despite this broad inclusion, interviewees reported that some MCOs had difficulty comprehending exactly what that provision meant for their organization:

The main problem that occurred is that the managed care organizations had not typically dealt with the commitment issues at all...so it was a whole new field for them to get into paying for commitment services...and a lot of other services that were seen as social services.... If you have managed care organizations that are essentially insurance companies, they don't know what you're talking about when you talk about civil commitment and some other services.

These conceptual difficulties notwithstanding, respondents reported that the frequency with which the civil commitment process is used throughout the State "has remained pretty much constant." Only the passage of the Chapter 980 legislation appears to have had any dramatic (and unanticipated) impact on the number of individuals who are civilly committed to treatment.

What has changed, and presumably for the better, is the way in which some of the regional courts order individuals into treatment. Said the interviewee from the State Medicaid office:

In Milwaukee County, I think [Medicaid managed care] has made a difference in how the judges do the court orders and how that process occurs, particularly in child protective services. They're much more cognizant

of who the HMO's provider networks are. They're much more careful to assure that the HMO's provider of choice is ordered in the court order or giving them the flexibility.

In short, the judges now work more closely with the HMOs to determine how to best serve the consumer and in a way that she or he does not lose coverage by accepting out-of-network treatment.

Are there anticipated changes to future managed care contracts to limit the use of civil commitment? What experiences have prompted these potential modifications?

None of the respondents reported any significant changes to future contract provisions; rather, they anticipate "fine-tuning" of what is already in place.

Case Study B

Colorado Medicaid Managed Care Contract and Civil Commitment

Overview

Colorado began operation of its statewide Mental Health Capitation and Managed Care Program in August 1995 under a Section 1915b waiver. The waiver was renewed in March 1998 and will extend until March 2000. The program is administered by the Department of Human Services, Mental Health Services, under a written memorandum of understanding (MOU) with the Department of Healthcare Policy and Financing (the State Medicaid agency). All adults and children who are enrolled in AFDC/TANF, who receive SSI, or who are dually eligible are mandated to enroll in the program. A total of 238,570 individuals were enrolled in fiscal year 1998.

Under the mental health waiver, eight Mental Health Assessment and Service Agencies (MHASAs) provide the services. The MHASAs, which are at full financial risk, are organized on one of four different models:

- Community mental health centers (CMHCs) that operate independently as MHASAs and are responsible for both administration and service delivery.
- A CMHC consortium (Behavioral Healthcare Incorporated [BHI]) that was formed by three CMHCs when the State combined their three service areas into one managed care region. BHI serves as a behavioral health managed care organization (BHMCO), processing claims, authorizing services, and credentialing providers. BHI pays State hospitals a capitated rate and negotiates fee-for-service payments with both private hospitals and providers.
- Partnerships between a BHMCO and CMHCs. In these arrangements, typically the CMHC provides mental health services, triages patients, and makes referrals for services not offered by the network. The BHMCO provides management information services, claims processing, utilization review and management, and other administrative services.
- A nonprofit HMO with an administrative services organization (ASO) arrangement. This is the newest model of the four and is currently operating only in the Denver area. It differs from the others in that the State has contracted with a nonprofit HMO (rather than a nonprofit CMHC) that will subcontract with several of Denver's behavioral health care

providers. A private for-profit MCO will be the ASO in this area of the State.

According to a recent report, the carve-out plan in Colorado was able to realize a significant expansion in community mental health services by reducing the system's reliance on costly inpatient services (GAO, 1999). For example, between fiscal year 1992–93 and fiscal year 1995–96 (the year after the capitated plan was implemented), the number of clients receiving inpatient services decreased from 3,046 to 2,058 and the number of inpatient days dropped from 93,151 to 19,959. Not surprisingly, the inpatient expenditures during this time dropped from nearly \$30.5 million to \$9.7 million. At the same time inpatient expenses decreased, the expenditures on other services—including supports within the community—significantly increased. In fiscal year 1994–95, approximately half (50.6%) of the State's mental health resources were spent on inpatient services, while the remaining funds (49.4%) were spent on all other mental health services. A year after the implementation of the Medicaid managed mental health plan, inpatient services consumed only 17.2 percent of the budget, while all other services received some 82.8 percent of the resources (“Colorado Mental Health Capitation Pilot Program Final Report,” p. 3).

Thus, at the very least, Colorado's Medicaid managed care plan has helped shift the locus of treatment in the State, from inpatient settings (where consumers were often court-ordered) to settings within the community. The assumption behind this change in the service delivery structure has been that if the community supports are enhanced, then consumers are more likely to be able to maintain functioning in the com-

munity and therefore less likely to be civilly committed to an inpatient facility.

Has the State addressed civil commitment in its managed care contract?

The State of Colorado addressed the issue of civil commitment extensively in its 1997 request for proposals (RFP). Although civil commitment is not covered in the Medicaid managed care contract per se, the terms of the contract require bidders to abide by all of the provisions of the RFP. The following provisions related specifically to court-ordered services under Medicaid managed care are included in the 1997 RFP:

The contractor shall provide any and all mental health services to an enrolled client that are ordered by a court of law. This includes inpatient hospital services, when those services are of benefit to the program, such as the State Mental Health Institutes for clients under twenty-one or over sixty-five. The contractor may not under any circumstances refuse to provide authorization or pay for services ordered by the court, even if the contractor determines that the services are not clinically necessary to treat a client's covered diagnosis. In the event the contractor believes the services ordered are not clinically appropriate or necessary, the contractor is encouraged to work with the courts and with any other involved agencies ...to revise the court order to include a more appropriate plan of care.

The contractor also is encouraged to work cooperatively with the judicial, child welfare, and other systems, as appropriate, to try to impact the appropriateness of court orders upfront. By working cooperatively with judges and other officials about the availability of appropriate alternatives, the contractor may be able to [reduce] incidences where a court orders a serv-

ice that the contractor believes is not clinically appropriate or necessary.

When a request is made to the contractor by a health or human services agency...to provide psychiatric evaluations that are needed for a court proceeding, but have not been specifically ordered by the court, the contractor shall provide evaluation services that are clinically appropriate for the client. The contractor shall use criteria developed jointly by the contractor and the county department to determine the appropriate evaluation services. The contractor is not required to provide evaluation services that are requested, but are not appropriate for the client.

Additional issues related to civil commitment, such as the IMD exclusion and definitions of medical necessity, are addressed in other areas of the RFP. These issues are discussed in greater detail in the pages that follow.

Does the contract clearly specify whether and under which circumstances the MCO is responsible to pay for court-ordered (services)? What was the rationale for including this provision?

As noted in the response to the previous question, the 1997 RFP for the Colorado Medicaid Managed Mental Health Care Plan is explicit about the contractor's fiscal responsibility for court-ordered services. As one State Medicaid representative summarized it, "[The contract] says you've gotta do it and pay for it even if you don't think it's necessary." When asked to discuss the rationale for the development of that language, he offered that court-mandated treatment was a benefit under fee-for-service and the State wanted to ensure that it remained a covered benefit under the managed care plan. Although the MCOs now bear the risk for such services, the interviewee noted that they have an opportunity to reduce the risk

by working with the courts to find less costly alternatives to hospitalization. Thus, although the RFP provisions may not affect the frequency with which courts mandate treatment for mental health consumers in Colorado, civilly committed consumers theoretically should receive a more appropriate level of care under the terms of the contract because of the encouragement of dialogue and cooperation between the courts and contractors.

Does the contract clearly specify where court-ordered hospitalization will take place and whether the MCO is responsible to pay for IMD care? If so, how is it addressed and what led to the adoption of the provision(s)?

The contract does not specify where court-ordered treatment takes place, only that a court may mandate that treatment occurs. Historically, most court-ordered evaluations and treatment took place in the State hospitals (IMDs). These hospitals were often far from the consumers' communities, sometimes upward of 150 miles, and the care they provided was costly. With the movement to a managed care arrangement, a system was developed wherein the State allocates and pays for a certain number of IMD beds to each MHASA. If an enrollee requires inpatient services and the allocated beds are full, the MHASA is then responsible for the cost of the enrollee's inpatient treatment, whether that treatment occurs in an IMD or a community hospital. By establishing these provisions, the State thereby reduced the incentive for the contractors to cost-/client-shift through the use of civil commitment. The interviewees noted that there is a push for judges to work closely with providers and contractors in order to match consumers with appropriate levels of care.

Does the contract address issues related to what services will be deemed medically necessary and how this determination will occur? Why were the particular provisions adopted?

The 1997 RFP for the Medicaid managed care contract does address how medical necessity will be determined, but does so in a manner that is “pretty general,” according to the State Medicaid agency representative. Section 37 (“Covered Diagnoses”) of the RFP reads as follows:

The contractor shall provide all mental health service necessary to treat a diagnosis that is included in the Mental Health Capitation and Managed Care Program. For clients who have both a covered and a non-covered diagnosis under the Program, the contractor shall provide all necessary services to treat the covered diagnosis, whether this diagnosis is the primary diagnosis or a secondary diagnosis. Substance abuse, alcoholism, mental retardation, and organic brain syndrome are not considered psychiatric illnesses under the Colorado Medicaid Program and the contractor will not be responsible for treating these illnesses.

This provision is augmented by Section 38 (“Mental Health Services”), which reads as follows:

The contractor shall provide all necessary mental health services to all Medicaid clients enrolled in the Mental Health Capitation and Managed Care Program. All clinical services shall be provided by qualified staff, and shall be appropriate for the client’s age and diagnosis. Clinical services also shall be culturally appropriate, as necessary.

According to the State Medicaid representative, the rationale for adopting this broad approach was to discourage any tendency among the managed care contractors to

underserve consumers (i.e., denying services on the basis of failure to meet medical necessity) in an effort to retain revenues as profits. Thus, the contractor’s choice is not whether or not to treat an enrollee whom the court determines has a mental illness, but rather to determine the level of care that is deemed appropriate to address the consumer’s diagnosis.

Does the contract require the types of community support services necessary to maintain client functioning? Are there other provisions intended to ensure the availability of adequate community supports?

The Medicaid Managed Mental Health Care contract in Colorado limits the MHASAs to a 5-percent profit and requires that all monies in excess of that 5 percent be reinvested into community support programs for non-Medicaid consumers. There are no reinvestment requirements aimed at enhancing community supports for the Medicaid-eligible population. The 1997 RFP, however, does require that on the first day of the contract, the contractor have in place such services for the community as partial-day programs and psychosocial rehabilitation programs. In addition, Section 40 (“Additional Services”) of the RFP “expects” the contractor to offer such non-traditional services as respite care, consumer drop-in centers, “warm lines,” early intervention services, peer counseling, and other support services. As with other managed care arrangements, this array of services serving the community is regarded as integral to helping consumers to maintain functioning in the community and thereby precluding decompensation and the need for a civil commitment order.

Does the capitation rate include the cost of court-ordered services? Is there some form of incentive in the contract that would encourage the use of civil commitment?

As noted previously, the capitation rate does include the cost of court-ordered services. There is no provision in either the contract or the RFP, however, that clearly would encourage the use of the civil commitment procedure. Indeed, both the contract and the RFP have been structured in order to discourage the use of civil commitment to shift clients/costs from the contractor to the SMHA. Even if a consumer is civilly committed, the plan must pick up the costs of all treatment (except for allocated IMD beds, as discussed previously). This provision prevents the MHASAs from using civil commitment as a way to remove high-cost clients from their caseload.

How do stakeholders believe these contract provisions (or lack thereof) have affected the use of civil commitment within each system?

The State of Colorado has collected some limited quantitative data on how many Medicaid eligibles have been court-committed to inpatient facilities since the advent of Medicaid managed care. Because of the lack of clear baseline (i.e., premanaged care) data, however, we have relied in this report on stakeholder perceptions. Overall, individuals reported no readily identifiable adverse consequences. For example, an individual from the State Mental Health Services Division offered the following statement:

I don't think [managed care] has had any impact on [the use of civil commitment]. I think it's been about the same....We changed our law last year...to include a couple of other

people who could take out holds,¹⁸ and people thought that would really increase [the use of holds and civil commitment]. We don't have this year's or this past fiscal year's data, but I haven't been hearing complaints from agencies saying that there's been a lot of inappropriate holds....So I don't really think it's had much of an impact.

Similarly, the individual from the State Medicaid Agency offered this positive perspective:

In general it has led to better education by the criminal justice system and the child welfare system of the mental health system and better collaboration and cooperation and in most cases more appropriate treatment....There were some bumps in the road to begin with, [but] uniformly now [the Directors of Social Services] say that the availability of service and the quality of service and the coordination of care is significantly better under managed care than it was under fee-for-service. And there's a much broader range of services available, which was our intent to begin with by going to managed care.

Such perspectives are perhaps not surprising, particularly given the State's concerted effort to include provisions in the managed care contract that aimed to reduce the MCOs' incentive to use civil commitment procedures.

Are there anticipated changes to future managed care contracts to limit the use of civil commitment? What experiences have prompted these potential modifications?

Interviewees did not suggest any significant overhauls of the Medicaid managed mental

¹⁸ The new categories of individuals who could file commitment petitions on mental health consumers included licensed professional counselors and marriage and family counselors.

health care contract in the next RFP, noting, “It’s more tweaking around the edges than it is significant changes in the overall system.” Most of the “tweaks,” in fact, were not around the content of specific contract provisions, but in their form. The representative from the State Medicaid agency stated the following:

Previously we encouraged people to have school-based services. The new RFP requires school-based services.... Previously we encouraged memorandums of working relationships with juvenile justice. The new RFP is going to require memorandums of understanding with those entities.... We found that permissive language was not adequate to get the job done.

The language of the new contracts will not assume that the contractors will provide desired services for consumers, but rather, will mandate what services the health plans should provide.

Case Study C

Iowa Medicaid Managed Care Contract and Civil Commitment

Background

In March 1995, Iowa received a 1915b waiver that allowed the State to create a managed mental health plan (Mental Health Access Plan) and a separate managed substance abuse plan (Iowa Managed Substance Abuse Care Plan). As of January 1999, these two stand-alone plans were combined into the Iowa Plan for Behavioral Health. The State mandates enrollment of the Medicaid-eligible population into the Medicaid carve-out plan, and currently has an average monthly enrollment of 180,000 individuals. The Iowa Plan for Behavioral Health is contracted for the

entire State with one for-profit company, Merit Behavioral Care of Iowa (MBC of Iowa, or MBC). MBC has providers throughout the State and bears full risk for the plan.

The consensus among the Iowa interviewees for this study is that the Iowa Plan appears to be working well for the State’s behavioral health consumers. Interviewees and independent reviewers noted that one of the key factors in the Plan’s success is that the system is able to use the flexibility that is possible under capitation to tailor mental health services to the special needs of the consumers. For example, MBC has helped to create strong community supports, such as crisis centers and outreach teams; fostered the use of telemedicine in rural areas; and even used funds to help severely disabled consumers acquire needed household items. Although the funding of these areas may be unusual for a managed care company, such interventions illustrate how contractors can be flexible in designing individual treatment plans while remaining at financial risk for their choices (GAO, 1999).

MBC benefited from the expansion of these nontraditional community services because of the concomitant decrease in the need for costly inpatient services. In Iowa, the carve-out reduced the percentage of expenditures for inpatient psychiatric care from 51 percent under the previous fee-for-service (FFS) program to 26 percent for inpatient care in the first year of the Iowa Plan. Moreover, under capitation, 21 percent of expenditures—nearly \$9 million—went for community services that were not previously covered under Medicaid FFS programs (GAO, 1999). MBC reported that such enhancements of the community service system—including the contractor’s establish-

ment of a community reinvestment fund—has reduced the need for both court interventions and expensive inpatient treatment.

Since Merit Behavioral Care of Iowa began its Statewide coverage, there have been two versions of the Medicaid managed care system. The initial waiver (resulting in separate mental health and substance abuse plans) was approved in 1995 and renewed in 1997. A waiver that brought the mental health and substance abuse plans together replaced this arrangement in 1999. Because the State has gone through multiple iterations of contract development, it thus offers an interesting example of development over time. It was evident from our discussions with individuals in this State that the current managed care contract was the result of an ongoing learning process. Through several rounds of contracting, the State Medicaid Agency and MBC were better able to realize what an effectively structured managed behavioral health care contract should contain, as well as what language should be avoided. Because they had taken advantage of the opportunities to refine the contractual relationship, no changes were deemed necessary or were being planned for the next wave of contracting.

Has the State addressed civil commitment in its managed care contract?

Of the several States we examined in this study, Iowa appears to have given the greatest amount of consideration to the issue of civil commitment under Medicaid managed behavioral care. While this issue was addressed under the two 1995 carve-out plans, the 1999 Iowa Plan for Behavioral Health is more detailed and comprehensive than its two predecessors. Some of the most recently adopted provisions include an agree-

ment that Merit automatically will cover the cost of a 5-day emergency mental health evaluation for enrollees; the expansion of the concept of “medical necessity” so that the criteria are more appropriate for this population of consumers; and the inclusion in the contract of incentive-based performance indicators that encourage MBC to decrease the use of court interventions. These provisions and related contract language are discussed in greater detail below.

Interviewees report that these provisions are the result of strong relationships between the State Mental Health Authority, State Medicaid Agency, Merit Behavioral Care, and various stakeholder groups. These relationships have allowed for continual dialogue among system participants leading to ongoing improvements to the terms of the contract. In addition, MBC has invited and convened roundtables for various groups of stakeholders, clinicians, judges, and consumers to offer feedback about the mental health system. By using such mechanisms, the State can readily identify new problems with the civil commitment process and stakeholders can collaborate in the development of a workable solution.

Does the contract clearly specify whether and under which circumstances the MCO is responsible to pay for court-ordered (services)? What was the rationale for including this provision?

Under the terms of the contract, 5-day inpatient mental health evaluations (i.e., emergency commitment) are always paid for by MBC of Iowa and are considered medically necessary without review. The managed care company will cover the treatment under an extended civil commitment order if the treatment both meets the criteria for medical necessity and is offered by a network

provider. There are exceptions that will be discussed below. These provisions were put into place through Letters of Commitment between the State Medicaid Authority and MBC under the 1995 contract, but were included as an integral part of the 1998 RFP.

According to the State Medicaid representative who was interviewed, the inclusion of civil commitment within the managed care contract was intended to control inpatient utilization rates. Prior to the implementation of Medicaid managed care, she noted, an individual who was court-ordered for a mental health evaluation might wait in an inpatient facility for up to 30 days before that evaluation was completed. If the evaluation indicated the need for further treatment, then the consumer might be ordered to an additional 90 days of inpatient treatment. "There was a desire to get that type of utilization under control, and also a desire to be responsive to the needs of our clients and to the needs of the courts in Iowa," she stated. Contracting such services to the MCO appeared to be the most expeditious means of getting these utilization patterns under control.

The representative from MBC acknowledged that, indeed, the company had accepted risk for evaluation periods in an effort to control costly inpatient utilization. Because of the historically long evaluation periods (and the associated high costs), MBC established that it would pay automatically for a 5-day evaluation stay in an inpatient facility. She noted, however, that cost considerations were not the sole reason behind the company's willingness to cover this expense. Originally, the representative said, Merit Behavioral Care had agreed to pay for any 5-day mental health evaluation that occurred in a community hospital, but not any that

took place in a State hospital. This provision was intended to benefit the consumer, because, the MBC representative notes, "the closer you can keep people to their home communities, the better off they are." Not only would the evaluating physicians have easier access to the consumer's support network, but also the consumer's life would be less disrupted by receiving ongoing treatment in his or her home community. "Iowa is not a large state," she said, "but at the same time there is a distance between some of our counties and where our mental health institutions are. Once you transport that client [to a State hospital] for a mental health evaluation it is more likely that they just may stay there."

The contract ultimately required MBC of Iowa to pay for any 5-day mental health evaluation, regardless of where it occurred. The managed care contractor accepted this provision in an effort to discourage the use of the courts as a way to gain access to services for consumers. The representative made this statement:

People were concerned that because we were managing care that we would deny services. There was a tendency to think that the only way to get services was through court action and so we had to demonstrate that no, that was not the case....The more you can have it be voluntary and have people agreeing that they need treatment, your success rate is likely to be greater.

Does the contract clearly specify where court-ordered hospitalization will take place and whether the MCO is responsible to pay for IMD care? If so, how is it addressed and what led to the adoption of the provision(s)?

Under the Iowa Plan, court-ordered hospitalization can take place either in a hospital

that serves the community or in State psychiatric hospitals, the latter of which meet the Medicaid IMD criteria. The managed care contractor must pay for any court-ordered services that are provided in a community hospital and that are within the contractor's utilization review guidelines. The counties in Iowa are responsible for IMD treatment costs. Because the State wanted to avoid the possibility of the MCO shifting costs to the counties, however, the 1995 contract (and the current contract for the Iowa Plan) included a provision that counties cannot be required to make higher IMD payments than they paid prior to the implementation of the managed care plan. Merit Behavioral Care's representative said the following:

[This provision] was set up so that there could not be cost-shifting or the perception of cost-shifting. And what they look[ed] at was how much a county had paid to mental health institutions prior to managed care. If that county...spent more than that amount, we [MBC] would pick it up and we would pay for those costs over and above that. And that was a way to insure to the counties that we had no incentive to cost-shift to the counties by Court Orders to mental health institutes.

Does the contract address issues related to what services will be deemed medically necessary and how this determination will occur? Why were the particular provisions adopted?

The Iowa Plan contract is quite explicit about the criteria for determining the medical necessity of a particular behavioral health service. Substance abuse services must meet what are termed "service necessity" criteria in Iowa, and all mental health services are required to meet the criteria for "psychosocial necessity." The contract notes that this "is an expansion of the concept of med-

ical necessity and shall mean clinical, rehabilitative, or supportive mental health services which meet" the standard criteria for medical necessity, but also require "consideration of

- the enrollee's clinical history, including the impact of previous treatment and service interventions;
- the services being provided concurrently by other delivery systems;
- the potential for services/supports to avert the need for more intensive treatment;
- the potential for services/supports to allow the enrollee to maintain functioning improvement attained through previous treatment;
- unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and
- the consumer's choice of provider or treatment location."

According to the State Medicaid representative, the contracting parties began to look at an expansion of the "medical necessity" criteria in the 1995 mental health and substance abuse carve-outs, but codified these new criteria under the terms of the 1999 Iowa Plan contract. She noted, "The concept of ordering somebody to a 30-day locked mental health ward just kind of had to give way to ordering somebody to an appropriate level of care."

Similarly, the representative from MBC noted the clinical importance of expanding treatment criteria beyond the traditional "medical model":

The State started managed care for mental health [on] March 1, 1995, and,

in that particular contract,...authorization for services was based on medical necessity criteria....It was not too long into the program when it became very evident that just basing decisions on medical criteria was really not going to be very workable for the population that we were serving....So we started expanding the definition for authorizations to what we call psychosocial necessity.¹⁹

While MBC of Iowa readily agreed with these expanded criteria, the State Mental Health Authority recognized that not every managed care contractor was likely to recognize the need for a broader standard for this population. Thus, in order to ensure that future contractors (should MBC lose the bid) abide by these standards, the expanded criteria were included in the RFP for the 1999 contract.

Does the contract require the types of community support services necessary to maintain client functioning? Are there other provisions intended to ensure the availability of adequate community supports?

The Iowa Plan requires that certain community support services be a covered benefit for enrollees. Among the services listed are Intensive Psychiatric Rehabilitation, Assertive Community Treatment, mobile crisis and counseling, peer support services, and supported community-living services. In addition, performance indicators are included in the 1999 contract to track the extent to which MBC is helping consumers remain in the community rather than in inpatient

facilities. For example, one incentive-based performance indicator tracks “community tenure,” the standard for which is that “the average time between hospitalizations shall not fall below 60 days.” A second standard that is simply being monitored by the State under the 1999 contract tracks “the instances when a higher level of service was required [because of] lack of needed community-based services....”

Does the capitation rate include the cost of court-ordered services? Is there some form of incentive in the contract that would encourage the use of civil commitment?

The cost of “psychosocially necessary” court-ordered services and 5-day evaluations are included in MBC’s capitation rate under the Iowa Plan. From interviews with stakeholders around the State, we learned there are no incentives in the Plan that might encourage the use of civil commitment. However, (as discussed above) there are specific provisions in the 1999 contract—as well as performance incentives in the Iowa Plan—aimed at reducing the use of civil commitment of people with mental illness.

How do stakeholders believe these contract provisions (or lack thereof) have affected the use of civil commitment within each system?

The individuals interviewed were unable to offer us any specific details as to what impact the contract provisions in the Iowa Plan (or its predecessors) have had on the use of civil commitment in the State. One individual believed that the contract “had an effect on it,” but added, “it’s not an easy, quick thing to describe.” When asked about any trends in inpatient admission rates or lengths of stay, she replied, “We do monitor that closely, but I can’t rattle numbers off the top of my head. I don’t know that I

¹⁹ At about the same time as Iowa was expanding its definition of “medical necessity,” other institutions were promoting similar efforts to bring the medical necessity standards more in line with the unique needs of the target population (see, for example, Bazelon Center, 1998).

could distinguish between a court-ordered and a non-court-ordered inpatient stay.” In point of fact, the majority of interviewees were unable to offer any commentary at all on the correlation between the Medicaid managed care contract and civil commitment. Thus, one could reasonably conclude that, at the very least, the Iowa Plan has not generated a noticeable change in the use of civil commitment of people with mental illness. Indeed, given the various provisions and incentives in the 1999 contract, it would appear that this State has taken great care to limit the use of court orders in providing behavioral health consumers with needed services.

Are there anticipated changes to future managed care contracts to limit the use of civil commitment? What experiences have prompted these potential modifications?

None of the interviewees mentioned any anticipated modifications to future Medicaid managed behavioral health care contracts, although the possibility of amending the 1999 contract was not ruled out. Indeed, it was made clear to us that the language in the Iowa Plan resulted from lessons learned through previous contracts and that the contracting process “must be seen as an evolution.” Since the adoption of Medicaid managed care in Iowa, elaborate mechanisms have been established throughout the State for stakeholder dialogue and feedback to MBC of Iowa. These mechanisms may lead to future contract changes. Experiences around civil commitment and service delivery under the current contract, however, were unremarkable enough to our interviewees that no changes were anticipated.

Case Study D

Minnesota Medicaid Managed Care Contract and Civil Commitment

Overview

In 1983, the Minnesota Legislature approved the Prepaid Medical Assistance Program (PMAP), a three-county demonstration project that used prepaid managed care plans to deliver health services to certain Medicaid enrollees, including families with children and the elderly. The Federal Health Care and Financing Administration approved the program in 1985. In 1995, under a 1115 waiver, the PMAP program was extended to 27 counties in the State. The current PMAP plan differs from some of the other Medicaid managed care plans in this study in that it was not designed to cover adults with serious and persistent mental illness (i.e., those individuals who are on SSI), but rather the AFDC/TANF population. Although some adults in the covered population may have a serious mental illness and a portion of the children may be coping with emotional disturbances, this plan was specifically designed to cover acute rather than chronic conditions. Even more significant, perhaps, is that PMAP is the one contract in these four case studies that does not cover the entire State population, a fact that might account for some of the unique developmental aspects of the contract that are discussed below.

In addition to PMAP (which is currently estimated to cover more than 162,000 enrollees in the 27 counties), three other health plans in the State offer coverage to such populations as the elderly and the working, uninsured poor. The State is also developing a five-county Demonstration Project for People with Disabilities (featuring

a behavioral health carve-out for the SSI population), scheduled to be implemented in July 2000. All of the Minnesota health plans are kept separate in terms of funding streams and contracting.

The PMAP arrangement is of particular interest to this study because although civil commitment was not addressed in the original contract language, it has been included over time through the passage of relevant legislation. PMAP thus offers a nice comparison with the comprehensive Medicaid managed care plans in Iowa and Colorado, which included provisions for civil commitment at the outset of their contracts. The following case study describes how past experiences are informing the development of future Medicaid managed care contracts in Minnesota.

Has the State addressed civil commitment in its managed care contract?

Interviews revealed that the original PMAP contract did not explicitly address the contractor's fiscal responsibility for an enrollee's treatment under a civil commitment order. Interviewees reported that one result of this oversight was a perceived rise in civil commitment for mental health consumers. Some interviewees speculated that this was the result of contractors attempting to shift costs to the State Mental Health Authority.

Consequently, legislation was passed and provisions adopted that attempt to limit the use of civil commitment within the context of the PMAP program. In addition, the new Demonstration Project for People with Disabilities will include more specific provisions around the health plan's responsibility for the costs of civil commitment. The relationship between Medicaid managed care and civil commitment in Minnesota can thus

best be understood as an evolutionary process in which lessons learned in the past are informing both the present and future Medicaid managed care contracts.

Does the contract clearly specify whether and under which circumstances the MCO is responsible to pay for court-ordered (services)? What was the rationale for including this provision?

Two pieces of legislation were passed in 1999 that clearly specify the circumstances under which the health plans are responsible for paying court-ordered services. This legislation was a response to actions by both the health plans and county agencies that were perceived to be having adverse consequences for consumers who had been court-ordered to treatment. In the first instance, PMAP contractors had been taking advantage of a loophole in private insurance law that treated civil commitment as a legal or administrative action, rather than a medical one. That allowed them to deny payment for court-ordered services for enrollees. In 1999, legislation was passed that prevented the health plan from denying the medical necessity of treatment simply because it was ordered by a court. This provision does not require the contractors to pay for all court-ordered services, but prohibits them from refusing to pay for treatment simply because it is ordered by the court.

The second legislative action delineated parties' roles and responsibilities during the civil commitment procedure. The process by which an individual gets civilly committed to treatment is uniform throughout the State of Minnesota: Whenever a commitment petition is filed, the county social service agency is required to do a prepetition screening. This screening aims to determine what the individual needs and if there are alternatives to a

commitment order. Prior to 1999, the county agencies conducted these screenings without obtaining any input from the managed care contractors. According to the State Department of Health representative, this arrangement proved disagreeable to both the counties and to the health plans:

There were complaints from both sides...counties were complaining that health plans were not agreeing to pay for court-ordered treatment and...were shifting costs onto them. But on the other side, the health plans were complaining that they weren't notified and didn't have an opportunity to have input into the court plan.

As a result, a second piece of legislation was passed in 1999 that required the counties to seek health plan input as part of the prepetition screening process. If the health plan is not notified of the proposed treatment or the court orders, then the county must bear the cost of the ordered treatment. The county may notify the health plan retroactively, although this then gives the health plan the option of not covering the cost of the treatment. Upon notification, the health plan must respond within 24 hours or automatically bear the cost of the treatment. If the health plan agrees with the assessment and the person is ordered for treatment within the health plan's network (or to an agreed-upon out-of-network provider), the health plan is responsible for the cost of the treatment. However, if the health plan determines that the treatment is not medically necessary, then the county is liable for the cost of the services.

These new laws have reinforced the health plan's responsibility to its enrollees who are placed on a civil commitment order, and clarified the plan's relationship with county social service agencies during the commit-

ment process. The overall aim has been to ensure that Minnesota's mental health consumers receive the appropriate level of care and that cost-shifting is avoided.

Does the contract clearly specify where court-ordered hospitalization will take place and whether the MCO is responsible to pay for IMD care? If so, how is it addressed and what led to the adoption of the provision(s)?

The contract does not specify where court-ordered hospitalization will take place, although most inpatient civil commitments in the past were made to Minnesota's State hospitals (IMDs). Because Federal regulations prohibit the use of Medicaid monies to pay for a Medicaid recipient's care in an IMD, State hospital inpatient expenses were not calculated into the capitation rate. Through Minnesota's 1115 waiver, a provision was incorporated into the PMAP contract that allowed health plans to use IMDs if they desired, as long as they were willing to pay for the cost of those services with non-Medicaid resources. This provision was designed to control State expenditures by preventing cost-shifting by the contractor.

Does the contract address issues related to what services will be deemed medically necessary and how this determination will occur? Why were the particular provisions adopted?

Interviewees reported that in the original PMAP contract, the determination of "medically necessary" care was a source of controversy. The interviewee from the Department of Health stated the following:

There are anecdotes where counties would tell us that somebody was enrolled in managed care and as soon as the court commitment came up they would get disenrolled from managed care. And the health plan would deter-

mine that the placement was either not medically necessary or that the proper approvals were not obtained.

Because of the ambiguity and its adverse impact on consumers, the State made two changes to its current contract. The first of these changes was to create a minimum Statewide definition of “medical necessity” that could not be overridden by a Medicaid contractor’s more stringent parameters. A State Department of Health representative offered the following rationale for adopting the Statewide standard:

In 1997, because of a lot of controversy around the definition of medical necessity, the mental health advocates, specifically the Mental Health Association, did get the legislature to adopt a Statewide definition of “medical necessity.”...medical necessity for mental health, which is used by health plans in Minnesota, cannot be more restrictive than a definition that’s spelled out in State law as of ’97....Before that it was pretty much wide open where they could just...make their own definition....

This legislation notwithstanding, the State still faced the problem (as noted previously) of contractors claiming that a court-ordered action, by definition, was not a medical decision. Because of this loophole, the health plan could disavow responsibility for the cost of court-ordered treatment. The State responded by passing legislation in 1999 that said that providers could not deny the medical necessity of care simply because it was court-ordered. By creating these changes, Minnesota thus was able to close loopholes that were perceived to have encouraged the use of civil commitment by contractors to shift the cost of high-need clients to the State and counties.

Does the contract require the types of community support services necessary to maintain client functioning? Are there other provisions intended to ensure the availability of adequate community supports?

None of the interviewees offered us any details on contractual requirements for community supports. It is thus assumed that no specific supports are required to be offered by the health plan, and that no provisions in the contract assure the availability of adequate community supports for mental health consumers. That result may be a consequence of the fact that the plan is primarily targeted toward the TANF population and acute care.

Does the capitation rate include the cost of court-ordered services? Is there some form of incentive in the contract that would encourage the use of civil commitment?

As noted earlier, the initial capitation rate in Minnesota did not include the cost of IMD services (which comprised an estimated 90 to 95 percent of civil commitment), but only of those services based in community hospitals. One interviewee believed that the loss of the monthly capitation payment would be a financial disincentive for the health plan to use court orders to IMDs as a way to shift costs to the counties. Other interviewees, however, felt that the health plans had routinely used this contractual loophole as a way to remove high-cost consumers from the plan. Thus, while the IMD payment issue was certainly not a direct encouragement to use civil commitment, it appeared to have left the door open for health plans to disenroll high-cost consumers via the civil commitment process. Through the 1115 waiver that was obtained in 1995, health plans were explicitly allowed to use

IMDs only if the plan covered the cost with non-Medicaid resources. This contract provision intended to eliminate the cost-shifting incentive that had inadvertently been included in the original PMAP plan.

How do stakeholders believe these contract provisions (or lack thereof) have affected the use of civil commitment within each system? If there has been change, is it perceived as positive or negative? Why? Do perceptions vary by stakeholder position? The State of Minnesota has not tracked how civil commitment has changed under the Medicaid managed care program. Information consists only of interviewees' perspectives on what impact managed care had on civil commitment. A State representative, for example, commented that after the shift to the PMAP plan, there were concerns about a possible increase in the use of civil commitment. He noted that several system and policy changes occurred simultaneously, thus making it hard to distinguish what factor may have caused the perceived change:

At the same time that managed care was implemented, the State Medicaid program also shifted payment [from] a fee-for-service inpatient care [on] a per-day system to a per-admission payment system...like Medicare does with the diagnostic related groupings. So as of about 1984–85 all Medicaid inpatient payments started to be made on a flat rate per admission. So that put a lot of pressure on [reducing] longer stays. And it's the court-ordered treatment that tends to be the longer inpatient stay.... But as lengths of stays dropped, it was more and more difficult for people to get the inpatient treatment that they needed in community hospitals. The State institutions got to be more and more difficult to get into and so court commitment came to be used more and more as a way to get into

State institutions. Soon after that, managed care started to be implemented and a lot of people felt that managed care had a lot to do with increases in court-ordered treatment, but we feel that's debatable. I mean it's hard to isolate the effect of one thing over the other.

An interviewee from an advocacy organization stated that the way in which the contract was initially set up was perceived to have created adverse consequences for consumers:

Prior to that (1999 legislation), the concern was that health plans could use an IMD setting as a cost-shift from their financial responsibility to the State of Minnesota....Once the court ordered treatment, the health plans would basically...lose the financial responsibility for that treatment because that treatment was not considered medically necessary....We don't have the data that shows that this would happen...you know, nobody admits to it, but everybody suspects that that was probably a motivator in at least some of the cases....As a state, [we] kind of forgot about the fact that a person has...deteriorated to the point where their medical condition suddenly [is] a social condition, too, where the dangerousness comes in to themselves or to other people. I think the State almost enabled the health plan to use the argument of medical necessity [as a means of denying payment]....

This perspective was corroborated by a third interviewee, whose familiarity with the prepetition screening process in Hennepin County led him to surmise the following scenario under Medicaid managed care:

Most commonly what we see...is that that person will have been...in the [private] hospital...three or four times prior to the time that [the hospital]

ask[s] for [civil] commitment....[Each time], the person was discharged as ‘stabilized’ from the hospital...but in reality [she or he is] really not much better than the time they entered the hospital. But after going through the sequence of three or four hospitalizations, [the hospital has] established a record that this person needs longer term hospitalization. [So] they come to the court...asking for a petition for commitment to the State hospital. When they’re committed to the State hospital, there is no longer any participation by the...managed care program....It’s all taken over by the State at ninety percent of the cost and the county for ten percent of the cost. So part of the goal is to get rid of the person, eliminate ‘em from the managed care system and put ‘em in the State hospital system where other people subsidize the long-term care. We see this repeated in Hennepin County over and over again.

Stakeholders’ perceptions would suggest that there has been a steady increase in the incidence of commitment orders since the implementation of PMAP, although there are differing opinions as to the probable cause of this trend. Because of the lack of valid quantitative data and the simultaneous implementation of multiple policy changes, it is impossible to determine with any accuracy how the move to Medicaid managed care has affected the use of civil commitment in this State. Indeed, in the absence of hard data, additional research would be unable to clarify either the extent to which there have been any changes, or the reasons for any such trends.

Are there anticipated changes to future managed care contracts to limit the use of civil commitment? What experiences have prompted these potential modifications?

As noted throughout this case study, the original contract for PMAP in Minnesota included no explicit references to the contractor’s responsibility for an enrollee who received a civil commitment order. As a consequence of lessons learned over the past few years, legislation has been passed and contractual amendments made in an effort to clarify the health plan’s responsibilities within the context of court orders. These amendments have been extended to the Demonstration Project for People with Disabilities (the managed care behavioral health carve-out for the severely and persistently mentally ill population), which will have explicit contract provisions around civil commitment and the contractor’s responsibility. For example, as noted earlier, the contract for the Demonstration Project will define “medical necessity” to automatically include court-ordered treatment. Said one of the contributors to the Demonstration contract process, “By that statement we get out of all this argument about whether a particular court-ordered treatment is medically necessary.” In addition, the capitation rate will include supplemental funding to allow health plans to cover up to 45 days of inpatient treatment in an IMD, such as a State psychiatric facility. This provision should effectively eliminate the incentive for a health plan to use civil commitment as a way to remove high-need consumers from the managed care plan’s rolls.

